DOCUMENT RESUME

ED 380 012 HE 028 127

TITLE	Medical Education and the Supply of Health Professionals. Hearing before the Committee on Finance. United States Senate, One Hundred Third Congress, Second Session.
INSTITUTION	Congress of the U.S., Washington, D.C. Senate Committee on Finance.
REPORT NO	ISBN-0-16-046649-0; Senate-Hrg-103-927
PUB DATE	8 Mar 94
NOTE	99p.
AVAILABLE FROM	U.S. Government Printing Office, Superintendent of Documents, Congressional Sales Office, Washington, DC 20402.
PUB TYPE	Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Family Practice (Medicine); Federal Legislation; Hearings; Higher Education; *Labor Supply; *Medical Education; Medical Schools; Medical Services; Nursing Education; *Physicians; Policy Formation; *Primary Health Care; *Public Policy; Supply and Demand
IDENTIFIERS	Clinton Administration; Congress 103rd; *Health Care Reform; Health Delivery Systems; Health Personnel Shortage; *Health Policy; University of North Dakota

ABSTRACT

The Senate Committee on Finance met to hear testimony on and discuss the preparation of medical doctors and how the Clinton Administration's proposed health care reform would influence medical education and the supply of health care professionals. Peter P. Budetti, director of the Center for Health Policy Research at George Washington University (Washington, D.C.), testified on how past federal policy has contributed to the rise of doctors training in specialties and subspecialties and has caused a decline in general practitioners. Jack M. Colwill, representing the Council on Graduate Medical Education, testified that the nation has too few generalists, has a surplus of specialists, and is moving toward a progressive physician surplus, which may impede the ability to move into systems of managed care and may contribute to escalating costs. Debra J. Folkerts, a family nurse practitioner from Kansas, testified on graduate nurse education and other health care reform efforts. Clayton E. Jensen, dean of the University of North Dakota School of Medicine, testified on how his institution has responded to North Dakota's health care service needs. The document also includes statements from Senators Orrin G. Hatch, Daniel Patrick Moynihan, and Bob Packwood and a position statement from the American Academy of Family Physicians. (JB)

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ED 380 012

S. HRG. 103-927

MEDICAL EDUCATION AND THE SUPPLY OF HEALTH PROFESSIONALS

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

MARCH 8, 1994

U.S. DEPARTMENT OF EDUCATION
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Printed for the use of the Committee on Finance

U.S. GOVERNMENT PRINTING OFFICE

83-267—CC WASHINGTON : 1994

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Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046649-0

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MEDICAL EDUCATION AND THE SUPPLY OF HEALTH PROFESSIONALS

TUESDAY, MARCH 8, 1994

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Daniel Patrick Moynihan (chairman of the committee) presiding.

Also present: Senators Rockefeller, Daschle, Breaux, Conrad, Packwood, Dole, Danforth, Chafee, Durenberger, and Grassley.

[The press release announcing the hearing follows:]

[Press Release No. H–14, March 4, 1994]

FINANCE COMMITTEE SETS HEARING ON MEDICAL EDUCATION

WASHINGTON, DC.—Senator Daniel Patrick Moynihan (D-NY), Chairman of the Senate Committee on Finance, announced today that the Committee will continue its examination of health care issues with a hearing on medical education.

The hearing will begin at *10:00 A.M. on Tuesday, March 8, 1994* in room SD–215 of the Dirksen Senate Office Building.

"The Committee will examine the factors that affect the number and type of physicians being trained today and how proposed health care reforms would influence medical education and the overall supply of health care professionals," Senator Moynihan said in announcing the hearing.

OPENING STATEMENT OF HON. DANIEL PATRICK MOYNIHAN, A U.S. SENATOR FROM NEW YORK, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. A very good morning to our distinguished panel and our guests at this most important hearing to which we have been looking forward for some time, on the subject of graduate medical education and the supply of health professionals.

As we all know, the President's proposal has rather strong provisions in this regard, not all of which have been welcome, not all of which have been deplored, and some of which are not understood.

I would like to take this happy occasion of a health care hearing to welcome Mark back; and to prove whatever else is, we have cured chicken pox. [Laughter.]

Do not underestimate those small advances in the culture.

Senator Packwood?

OPENING STATEMENT OF HON. BOB PACKWOOD, A U.S. SENATOR FROM OREGON

Senator PACKWOOD. Mr. Chairman, as usual I find this also a very interesting hearing. We are now going to try to guess, hopefully intelligently what kinds of doctors we need in the future and whether or not the Federal Government needs to direct us in that direction or whether or not we look back at our past experience and some of the choices we have made and perhaps exhibit a bit of caution as to whether or not we can guess correctly.

I guess a classic example of guessing incorrectly is the building of hospitals. In the past, we were convinced we needed four or five beds per 1,000 population; and now from the testimony we have had, most of them are operating in areas of 2½ beds per 1,000 population and are aiming toward one bed per 1,000 population. So we over built without any malice. We thought we knew what we were doing.

If we now say we are going to have a Federal program that determines who many general practitioners we should have and how many heart surgeons and how many brain surgeons and how many internists, will we guess correctly or are we better off to leave that to the marketplace knowing that as HMOs grow, and they have been growing, that they are going to hire more general practitioners? They are paying more now. And will that in and of itself be a sufficient inducement for people in medical school to change their programs from their present specialties to a general practitioner specialty?

I do not know. I do know, however, that as with many things involving medicine in the past, we have estimated wrong, we have guessed wrong. So at least we ought to be a little wary in being sure that we know what the answer is for how we should allocate medical education to different specialties.

The CHAIRMAN. I very much agree. As our panel is gathered, we are "primum non nocere" as is our standard here, and is a standard of seriousness we need if we want to do this well. We are not raising questions because we are trying to obscure the subject or make it more difficult, but rather to illuminate it.

It would help, I think, if any of you, as you move along, would care to comment on what Senator Packwood just said.

I would offer you a different view, sir, which is that when the hospitals were built you needed 4 to 5 beds per 1,000 persons and then medicine advanced in ways that one per 1,000 might be appropriate now.

Senator PACKWOOD. It advanced in a way we could not foresee.

The CHAIRMAN. But you can foresee changes. Well, let us hear from people who might know what they are talking about. [Laughter.]

And we do remember, we have to remember, as the chairman of this committee, Hon. Russell Long, once said of the Hill-Burton Hospital Construction Act, that that was the South's revenge for the Civil War. [Laughter.]

So we take that into account, too, as well. Let us see, Dr. Budetti, you are first and you are Director of the Center for Health Policy Research right here at George Washington University. You

are not just a doctor. I take it the J.D. means you are a lawyer, too.

Dr. BUDETTI. Yes, sir.

The CHAIRMAN. You are everyone's idea of a man. Anyone who falls into your hands is in trouble, or perhaps not. I am joking. Would you proceed, sir.

STATEMENT OF PETER P. BUDETTI, M.D., J.D., DIRECTOR, CENTER FOR HEALTH POLICY RESEARCH, THE GEORGE WASHINGTON UNIVERSITY, WASHINGTON, DC

Dr. BUDETTI. Good morning, Mr. Chairman, and thank you for inviting me here. Mr. Packwood, it is a pleasure to see you. I am very much at home with both you, having gone to medical school in New York and having been Chief Resident in Pediatrics at the University of Oregon. So, so far, so good.

I do want to speak on the issues that you have mentioned so far. I think it is clear that we are blessed with an abundance of physicians in this country and a number of physicians that is increasing very rapidly. I think the issue before us, as you have both quite properly stated, is the extent to which that blessing is to some degree a problem or even a curse, as some might put it, that we have either too many physicians or too many physicians going into the wrong fields.

The numbers certainly show where they are going. And the fact that another Federal policy, which was to greatly increase the numbers of doctors in this country just as we built a lot of hospital beds, was also very successful. And we did, in fact, as we built hospitals we also produced a lot of new doctors.

The CHAIRMAN. Was it not the Medicare Program that was associated with increasing medical education?

Dr. BUDETTI. Yes. And I think that that is one of the key points here, Senator, is that on the one hand we put a lot of money into actually increasing the number of people coming out of medical schools. But then through Medicare in particular we have put a tremendous amount of Federal dollars into stimulating those people to go into particular specialties.

I think that that is probably the key reason why it makes at least some sense to say straightforwardly, this is not exactly a pure marketplace. This is something that the Federal Government has put a lot of bucks in for a lot of years, dollars that certainly rise to the level that Senator Dirksen would have noticed, and they have been very effective in putting forth an atmosphere in medical education that has led physicians into specialties and subspecialties.

Now is that a problem? I think that is the key question for us, whether that is a problem or not. It certainly was not the result of a deliberate Federal policy to do so. The Federal policy was to put the money out there and the way that the money was spent led to this distribution of physicians into high technology, hospital-based intensive specialties rather than into primary care and we have seen a fall off in the number of primary care doctors.

The CHAIRMAN. Are you saying, if I could just interject——

Dr. BUDETTI. No, that is fine.

The CHAIRMAN.—the existence of the hospitals created the opportunity to specialize in certain ways that required a hospital and was, in a sense, a hidden policy. It attracted specialties that would not have developed in the absence of the hospitals themselves. So, there was a secondary effect that perhaps was not anticipated?

Dr. BUDETTI. Much better stated than myself, Senator. That is exactly what I was getting at, was that the presence of the hospitals, the flow of the money for specialty training to hospitals while primary care doctors by and large not only need to be trained inside of hospitals but outside of hospitals as well.

But since the money could not go to those other places outside of the hospitals and since the money was extremely useful to the teaching hospitals in the sense that it let them build up the specialties that bring in the greatest amount of revenue for the teaching hospitals, I think that we did see something of a marketplace, but a marketplace stimulated very heavily by Federal dollars, but to serve the parochial interests of the teaching hospitals and not to serve national policies overtly anyway.

I think that is the——

The CHAIRMAN. I am going to make one more.

Dr. BUDETTI. Sure.

The CHAIRMAN. We are familiar with unanticipated consequences. It was so stated by Robert K. Murtin, who published it at Columbia in 1935, and it is addressed regularly here. But there is something else also, is there not, that we have had a great age of discovery in medicine. And the attraction of these specialties has been in doing something not ever before done. Is that not so?

Dr. BUDETTI. Oh, I think that is very real. I think that the attraction of the specialties by and large has been on the one hand quite legitimate and quite real as there have been major medical advances that we are very proud of. I think we should all be very proud of what we have done in this country with respect to the advancement of learning in medical science over the last 30 years or so.

It is a major national triumph that we should be very proud of. But that is just not the only factor that I think should have gone into determining where medical students went on to practice and what specialties they went on to practice. I think that the medical students tended not to be exposed to people in primary care who were in high status positions and who were looked upon as of equal intellectual level as the people who were doing the sophisticated biomedical research and high technology procedures.

So being a highly select group in the first place, and wanting to emulate the best of the best, I think it is a natural attraction. That was certainly my experience in medical school and I think it has a lot of legitimate basis to it.

I think that what we have seen, though, is that there should be other factors that should come into play as well, including the need to just plain take care of people when you get out into practice and what it takes to learn what you need to know in order to be a good doctor to take care of people in the community.

Let me just make a couple of additional comments along these lines. One of the questions is, if this is an issue that the Federal Government has already put a lot of money into and has a big

stake in, what kind of measures should the Federal Government take?

As you said at the beginning, Mr. Chairman, first of all, do no harm. I think that is a very important point to keep in mind here. This is an area where I think there has been a great deal of study and analysis and preparation, trying to get ready for the point at which we could make some sensible policies to on the one hand increase the number of primary care trainees, of generalist trainees in medicine and on the other hand not to cause major problems that would undermine the progress that we have made in the more sophisticated—I should not, I am catching myself saying the same point and the same stereotype—in the more technologically based specialties.

So I think we are at a point now where, and we will be happy to discuss some of this this morning, where there are a variety of approaches, approaches that I think could achieve the aim of redirecting the distribution of physicians into the different specialties without interfering too greatly into local decision making, into the medical professional decision making, and into the kinds of structures that are necessary to preserve our great progress in high tech areas.

One final comment I would like to make, Mr. Chairman——

The CHAIRMAN. May I just say, do not hesitate to be brief just as you are doing, because you are the only panel we have this morning, it would be interesting if we heard each of your views and went back and heard them again; and then heard your views on one another.

Dr. BUDETTI. I will make one more point and then I will be happy to pass it along. The only other point I would like to make is, I think we need to focus on to clarify the difference between service delivery and training.

I think that if we look at many of the inner city areas where people are heavily dependent upon teaching hospitals for service delivery, those teaching hospitals play a very valuable role. But I have always viewed that as at best a stop gap measure.

I think that the people in the inner cities, like everybody else, deserve access to mainstream medical care. I think that that is why considering these policies and these changes in policies in the context of national health reform make so much sense. That at the same time we could try to redistribute the training while providing new ways to take care of people in the cities so that they are less dependent on the teaching hospitals, except when they need the sophisticated services available at the teaching hospitals.

So I think that it is very important for us to have in mind that service delivery solutions ought to go hand in hand as we try to redirect where the production lines of our medical industry are going. Just producing residents so that they are there for 3 years to take care of people in the inner city is not a long term solution to the service delivery needs of people in those areas. I think we need to keep that in mind.

Thank you, Mr. Chairman. I will be happy to respond to questions.

[The prepared statement of Dr. Budetti appears in the appendix.]

The CHAIRMAN. Thank you, Doctor. We will come back to this.

It may be noted, however, that probably three-quarters of the great teaching hospitals in the United States, which are the finest on earth, are located in what are called inner city slums. You know, I, in my youth, found myself at Columbia Presbyterian and I do not feel deprived. And I never saw a bill.

Where is Senator Danforth? Senator Danforth, are you here? [Laughter.]

Dr. COLWILL. I just received a note from the Senator.

The CHAIRMAN. You are nonetheless welcome, sir. [Laughter.]

I thought Jack was going to introduce you. He obviously has been summoned to the Commerce Committee where all sorts of crises are about.

Dr. Colwill is professor and chairman of the Department of Family and Community Medicine at the University of Missouri and he appears on behalf of the Council on Graduate Medical Education. Perhaps you would tell us just a little bit about what that council is and then go forward.

STATEMENT OF JACK M. COLWILL, M.D., PROFESSOR AND CHAIRMAN, DEPARTMENT OF FAMILY AND COMMUNITY MEDICINE, UNIVERSITY OF MISSOURI AT COLUMBIA SCHOOL OF MEDICINE, COLUMBIA, MO, ON BEHALF OF THE COUNCIL ON GRADUATE MEDICAL EDUCATION

Dr. COLWILL. I appreciate the opportunity to be here today. The Council on Graduate Medical Education was established by the Congress a little over a decade ago. Its role was and has been to make recommendations to the Secretary and to the Congress concerning issues of the physician work force. It has become progressively concerned about fundamental issues in the physician work force. That is why I am here today.

In a nutshell, we are concerned that this Nation has too few generalists, has a surplus of specialists and is moving toward a progressive physician surplus. These issues will impede our ability as a nation to move into systems of managed care.

We are concerned that the surplus will stimulate provisions of additional services that may not be fully necessary and consequently contribute to escalating costs.

And finally——

The CHAIRMAN. By surplus you mean an over supply?

Dr. COLWILL. Over supply, yes, sir.

The CHAIRMAN. We are trying to work out a lexicon in the committee.

Dr. COLWILL. And finally, as you know, shortages in the inner city and rural health areas have continued to be a problem. The fact that we have so few generalists is one of the major contributors.

I would suggest that you may want to review the figures in my handout. The first figure shows——

The CHAIRMAN. Would you give us the table number, sir?

Dr. COLWILL. Figure 1 in my handout, which is the COGME statement.

The CHAIRMAN. Good. Good.

Dr. COLWILL. This figure demonstrates the increasing number of physicians in our country over time. It also shows the increasing

ratio of physicians to population. Virtually everybody will say we have at least an adequate supply of physicians today. Many say we have an oversupply already. And yet we will continue to have an increasing physician supply at least until 2020 when numbers plateau. Further, between now and 2020, the physician to population ratio will increase by roughly a quarter.

The CHAIRMAN. Let us see, just to get a hold on these things. The demography is destiny in these things. That doctor in the year 2020 he or she was born 3 years ago?

Dr. COLWILL. I am sorry?

The CHAIRMAN. They were born 3 years ago, the doctors entering the stream in the year 2020. So they are already alive.

Dr. COLWILL. Right. Right.

The CHAIRMAN. In preschool and learning biology, elementary biology.

Dr. COLWILL. This projection is based upon what is happening today. It actually may be an understatement, because the number of physicians trained both in this country and abroad who are entering residencies appears to be increasing.

The CHAIRMAN. One last—I am sorry. Will everybody interrupt. Senator Durenberger, will you interrupt and stop underlining, if you please, as you please?

Senator DURENBERGER. Is this for lexicon purposes?

The CHAIRMAN. For database. If we are at, say, 240 per 100,000 population now, what is Canada?

Dr. COLWILL. Canada is roughly at the same level.

The CHAIRMAN. Canada is roughly the same?

Dr. COLWILL. Yes.

The CHAIRMAN. What is the U.K.

Dr. COLWILL. Much lower.

The CHAIRMAN. Half? Three-quarters?

Dr. COLWILL. It is roughly 150, I believe, something in that ball park.

The CHAIRMAN. It is 150 as against our 240. So it is almost half. France?

Dr. COLWILL. I cannot give you specific figures. It is roughly the same or more.

The CHAIRMAN. So we have twice the amount?

Dr. COLWILL. We are roughly in the middle of various nations in terms of our physician to population ratio. There are some that are much more than this. There are some that are significantly less.

Senator PACKWOOD. What are some of the ones that are more?

Dr. COLWILL. I believe Germany, Italy, Portugal are in that category.

The CHAIRMAN. I guess we had better find that out. All right?

Dr. COLWILL. I am told that Israel may have the highest number.

The CHAIRMAN. You are dead right. The OECD average is 230 and so are we. The U.K. is down. Germany has twice the U.K. Yes.

Dr. COLWILL. And when we get to the 300 figure, we will probably be at the top of where that list is right now.

The CHAIRMAN. Well, we are not off the chart at all.

Dr. COLWILL. No, we are not off the top. We are adding each year to our residency programs 24,000 new trainees, new residents. Of

that group, about 17,500 received their M.D. from U.S medical schools and roughly 6,500 are being trained in other countries.

The second Figure, demonstrates the declining percentage of generalists in our physician population. You can see that in the 1930s virtually everybody was a general practitioner.

Today we are roughly at one-third generalists. Figure 3 shows that only 26 percent of medical school graduates in 1989 entered practice as generalists.

The CHAIRMAN. What is a "D.O."?

Dr. COLWILL. Doctor of Osteopathy. Osteopathic physicians are a small proportion of the total physicians in this country.

We are now at the point where only about a quarter of medical school graduates are going on to careers as generalists. It is these figures that have led the COGME to be quite concerned about both the total numbers and the generalist/specialist supply.

We are investing roughly $6 billion a year in graduate medical education through Medicare. We are not in any way limiting the total number of positions or in any way making suggestions about their specialty distribution.

It is this issue that concerns COGME. COGME recommends that that graduate medical education funding be utilized to limit the total number of positions in graduate medical education and to move toward a 50/50 mix of generalists and specialists.

The CHAIRMAN. So you are coming here as a Chairman of a Board which we have created and you are saying you have a goal for us, you have a recommendation.

Dr. COLWILL. Yes.

The CHAIRMAN. Tell us again. You have a 110 percent goal here. You want fewer physicians than we are on our way to getting.

Dr. COLWILL. If you moved to Figure 4——

The CHAIRMAN. Yes, sir.

Dr. COLWILL.—our goal is to try to contain the physician population ratio at roughly today's levels.

The CHAIRMAN. Or limited to 110 percent.

Dr. COLWILL. If we limit it to 110 percent of the U.S. graduates, you can see it will still rise somewhat beyond that level.

The CHAIRMAN. Yes. Now does everyone hear that? This is an idea for having fewer physicians. This is the recommendation we are getting, not formally but in your testimony, and this is where you come out.

Dr. COLWILL. Yes, sir.

The CHAIRMAN. Do you find that the administration's bill is pretty much in sync with that?

Dr. COLWILL. I think the overall goals of the administration's bill and ours are very much in sync. We have somewhat different recommendations for how to get there.

The CHAIRMAN. Right. And, of course, we have an advantage, which not every country has, which is we often get superbly trained physicians from other countries. I think of India, for example. But you do not want us to get up to 300 per 100,000. You think 250, 260 is enough.

Dr. COLWILL. I think one of the fundamental questions that you have already posed is what is the appropriate physician number. I do not think we know. I think that——

The CHAIRMAN. Well, if you do not know, why do you have this goal?

Dr. COLWILL. Well, let me take it on.

The CHAIRMAN. It is very refreshing.

Dr. COLWILL. I think you will find a virtual consensus that the current supply is at least adequate.

The CHAIRMAN. I see.

Dr. COLWILL. Many will be saying that we are already in a surplus.

The CHAIRMAN. And just perhaps to use a rough analogy, the 4 to 5 beds per 1,000 that may or may not have been required 20 years ago and we now say one will do, gets better.

Dr. COLWILL. Yes.

[The prepared statement of Dr. Colwill appears in the appendix.]

The CHAIRMAN. Well, thank you very much, Doctor. We want to move along.

As I said, Senator Dole and Senator Rockefeller, we have only one panel this morning. Our witnesses are being fairly brief so we can have a lot of exchange with them afterwards.

Now the next witness you may wish to introduce yourself, is Debra Folkerts.

Senator DOLE. We are just happy to have Debra here. She has been helpful to us in the past and we appreciate very much your coming.

The CHAIRMAN. Again, for lexicon purposes, an ARNP is an accredited registered nurse practitioner.

Ms. FOLKERTS. Advanced Registered Nurse Practitioner, correct.

The CHAIRMAN. Good morning.

STATEMENT OF DEBRA J. FOLKERTS, A.R.N.P., FAMILY NURSE PRACTITIONER, MANHATTAN, KS

Ms. FOLKERTS. Mr. Chairman and members of the committee, I am Debra Folkerts, a family nurse practitioner from Manhattan, KS. I am a member of the Kansas State Nurses Association and the American Nurses Association.

Thank you for this opportunity to discuss graduate nurse education and other health care reform issues within the jurisdiction of this committee.

I am also testifying today on behalf of the American Association of Colleges of Nursing, the American Association of Critical Care Nurses, the American Organization of Nurse Executives, the Association of Operating Room Nurses, the Association of Spinal Cord Injury Nurses, the Emergency Nurses Association and the National Nurse Practitioner Coalition.

I am also here as a nurse practitioner who served for 3 years as the only primary care provider in a very small town in rural Kansas. I have always practiced in rural areas.

America's 2.2 million registered nurses deliver more essential health care services in the United States today in a variety of settings—hospitals, nursing homes, schools, home health agencies, the work place, community health clinics, and private practice and in managed care settings.

Nurses know firsthand of the inequities and problems with our Nation's health care system. Because we are there 24 hours a day,

7 days a week, we know all too well how the system succeeds so masterfully for some, yet continues to fail shamelessly for all too many others.

Nursing commends Congress for its increased focus on nurse education issues. It is clear that the U.S. health care system has an increasingly urgent need for primary care providers. Funding must be made available to strengthen existing advanced practice nurse programs and to establish new programs to prepare those primary care providers so urgently needed.

Nurses are well-positioned to fill many gaps in the availability of primary health care services. Advanced practice nurses are trained to provide from 80 to 90 percent of necessary primary care services of the Nation.

We are pleased the President's health care reform proposal contains a provision for funding for graduate nurse education. This would provide a stable ongoing revenue source to expand the production of advanced practice nurses, a vital resource for meeting health care needs.

Advanced nurse education includes the preparation of nurse practitioners, clinical nurse specialists, certified nurse midwives, and certified registered nurse anesthetists. These advanced practice nurses are prepared as expert clinicians to deliver primary care and other services vital to the Nation's health care needs.

The graduate nurse education program would help many graduate nursing students who are currently attending school part-time due to financial constraints to become full-time students.

The American Association and Colleges of Nursing found that based on 1988 dollars it costs a graduate nursing student about $36,837 without financial aid to receive a master's degree.

The costs of preparing the advanced practice nurses are currently borne almost entirely by the schools of nursing and the students themselves, each with very limited resources.

In order to quickly expand the number of these expert clinicians there must be an increased Federal commitment to graduate nurse education.

The CHAIRMAN. Could I just interject there to say that you mentioned the President's Health Security Act. You also mentioned Senator Chafee's proposal as addressing these concerns of yours.

Ms. FOLKERTS. On the issue of graduate nurse education, correct.

Education programs alone, however, will not solve nursing's ability to provide full, primary and preventive health care services. Certain artificial barriers prevent nurses from providing these services. The fastest way to expand the number of advanced practice nurses in this country would be to eliminate the barriers to practice and reimbursement, which prevent these nurses from practicing to their fullest capabilities.

Nurses were pleased to have the opportunity to work with Senator Daschle and this committee to achieve the enactment of the Rural Nursing Incentive Act, which enabled nurse practitioners and clinical nurse specialists who practice in rural areas to receive direct reimbursement under Medicare.

I know from personal experience the dramatic impact this law had on the access to health care for people in a small town in Kansas. Without this change in Medicare I, as a nurse practitioner,

could not have provided services to the 600 people of Glasgow, KS. My patients came from Glasgow and the surrounding areas—68 percent of them were Medicare beneficiaries.

Glasgow is located in Cloud County, KS, the third oldest county per capita in the Nation. Thanks to the change in Medicare I saw between 368 and 400 people per month, and I was their sole primary care provider. That law now needs to be expanded to cover the services of all nurse practitioners and clinical nurse specialists, regardless of geographic location and practice setting.

This expansion of coverage does not provide for reimbursement of new services, but rather provides for reimbursement of existing services in alternative cost effective settings by non-physician providers. By taking this action, these advanced practice nurses would provide essential services to meet the health care needs of older Americans who currently have no access to affordable health care.

Legislation to achieve this objective has been introduced by Senators Grassley and Conrad. We would urge you to ensure that this important proposal is enacted as soon as possible.

The Medicaid Program also needs to directly reimburse for the services of all advanced practice nurses so that they may be fully utilized by Medicaid recipients. Senator Daschle has introduced a bill to achieve that goal. This is a provision that must be adopted to increase access immediately.

Just as nurses have demonstrated their ability to provide high quality, cost effective and accessible health services, consumers have shown their widespread acceptance of these services and their willingness to continue receiving primary care services from nurses in advanced practice.

A recent Gallup poll revealed that the vast majority of Americans, 86 percent, are willing to receive everyday health care services from an advanced practice nurse.

Mr. Chairman, we are pleased that a number of members of this committee have introduced or co-sponsored bills that propose a variety of different approaches to reform of the health care system. This will ensure that this issue is comprehensively discussed and that all options are thoroughly considered.

We look forward to working with all of you. We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform is developed. I would be particularly happy to answer any questions regarding rural practice. Thank you.

The CHAIRMAN. Thank you, Ms. Folkerts.

[The prepared statement of Ms. Folkerts appears in the appendix.]

The CHAIRMAN. Could I just record here for the record that there are three times as many nurses in the Nation as there are medical doctors, a point to be kept in mind in terms of who is out there and who is giving health care.

And now just to conclude our panel's opening statements, Dr. Jensen, Dean of the University of North Dakota School of Medicine at Grand Forks. Where is Senator Conrad? Well, you are on your own, Doctor. You are very welcome, sir.

Senator DURENBERGER. Mr. Chairman, if I may, he really is not alone.

The CHAIRMAN. You are neighbors practically, yes.

Senator DURENBERGER. As testimony to the fact that health care really does not have State boundaries, there is no better example, as I think I have shared with you before, than the way in which the medical and health enterprise located in North Dakota has serviced about a quarter of the State of Minnesota, looking at it geographically.

The cooperation, the commitment, and I think the value system that Dr. Jensen brings to his discussion of community based medical education is something that I think a lot of us share. Since I have experienced it, and I have been there, and I have listened to him, and I have learned from them, in Kent's absence, I will certainly endorse your wisdom in choosing Dr. Jensen to speak for a lot of community based education.

The CHAIRMAN. Thank you very much, Senator Durenberger.

Dr. Jensen?

STATEMENT OF CLAYTON E. JENSEN, M.D., DEAN, THE UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE, GRAND FORKS, ND

Dr. JENSEN. Thank you, Senator Moynihan, and certainly Senator Durenberger. As to the point I was on my own, I think the comment was made a little bit earlier that is sort of reminiscent of what family physicians are sometimes in the middle of the night delivering a baby and things go to pot and you are basically there holding the fort down by yourself.

So I appreciate Senator Durenberger's comments. He is absolutely correct. Our residency training programs in North Dakota—and we have four of them—are responsible for much of the manpower and woman power, in other words health care needs in northwest Minnesota. So we see him as a very, very staunch ally and we thank him for that.

I am a family physician and practice as a family physician for 25 years in Valley City, ND. That has a tie, incidentally to Senator Dole, who has a nephew that is in Valley City, North Dakota.

I left Valley City after 25 years and went to the University of——

Senator GRASSLEY. Could you tell him who it is?

Dr. JENSEN. Yes, I can. [Laughter.]

Senator DOLE. He is a Republican. [Laughter.]

Dr. JENSEN. His name is Bill Jahn, to be exact. He is a pharmacist actually in Valley City.

But I did leave the private practice of medicine and joined the University of North Dakota. I am Chair of the Department of Family Medicine and am currently the interim Dean.

The CHAIRMAN. And Senator Conrad has just this moment arrived. We certainly want to welcome you.

Senator CONRAD. Good morning. Welcome, Dr. Jensen. [Laughter.]

Dr. JENSEN. Thank you.

I do want to make some comments. As a community based school we make extensive use of community facilities. We do not——

The CHAIRMAN. Can we just work on our lexicon? A community based school, and how would you distinguish that? You are referring to the University of North Dakota School of Medicine.

Dr. JENSEN. That is correct. And I am using North Dakota as a model.

The CHAIRMAN. Is Cornell University of New York Hospital not a community based school?

Dr. JENSEN. No, not in the sense or in the definition that we have.

The CHAIRMAN. That is what I want.

Dr. JENSEN. That is correct.

We make use of community facilities throughout the State. In other words, we have four campuses with our major cities—Bismarck, Fargo, Grand Forks and Minot—with our tertiary care facilities in those communities and with much of our teaching taking place at those types of facilities and with community hospitals throughout the State. We do not have a university teaching hospital.

The CHAIRMAN. I see. Yes.

Dr. JENSEN. I think that is important for everyone to understand. My discussions are going to center around the community based medical schools, of which North Dakota is one. There are actually a total of about 23 community based medical schools in this country, who consider themselves to be community based.

As far as primary care physicians are concerned, you will find that the percentages of primary care physicians come primarily from community based medical schools. Of the 13 community based schools, all but three, in other words 10 of those community based schools, have the highest percentage of its graduates that go into family practice, internal medicine or pediatrics.

So we have a vast amount of experience dealing with the specialties that are currently needed as we see it under health care reform and are needed, incidently by the country for the provision of primary care.

Senator PACKWOOD. Can I interrupt? Mr. Chairman, you said we could.

Explain to me again what a community based medical school is. Is that simply a non-teaching—I am not quite sure what it is.

Dr. JENSEN. Okay. Community based means that it uses as its resources facilities that are available within the communities. In other words, we will use, for instance, as Senator Conrad knows, the facilities of St. Luke's, and Dakota Hospital in Fargo, Fargo being our largest city and those being the two largest hospitals.

We do that around the State. We do not——

The CHAIRMAN. You do not build a university hospital across the street.

Dr. JENSEN. That is absolutely correct. And as a matter of fact, at least in my opinion, that concept of a large university hospital now has become somewhat of a dinosaur.

Senator PACKWOOD. Do you have a university hospital?

Dr. JENSEN. We do not.

Senator PACKWOOD. Okay.

Dr. JENSEN. We make absolute use of community based facilities, community based hospitals that is, general hospitals in our major communities and smaller communities throughout the State.

Senator PACKWOOD. Let me pursue further so I am sure I understand. So you do not have a teaching medical school?

Dr. JENSEN. Yes, we have a teaching medical school, but its teaching is done in community hospitals. So that the third and fourth years take place in those settings, plus in small communities throughout the State.

Senator PACKWOOD. The first 2 years take place in the more academic setting?

Dr. JENSEN. That is correct, up at Grand Forks, the first 2 years. You will find the curriculum that we have and the facilities that we use I think back in the appendices, which are about Appendix Two and Appendix Three as I recall.

The CHAIRMAN. And you make up about 20 percent of medical schools, is that what you said?

Dr. JENSEN. Well, there are 23 medical schools in this country that consider themselves to be community based.

The CHAIRMAN. And there are 128 medical schools altogether.

Dr. JENSEN. That is correct.

One of the things that we do in order to reduce costs is that we have about, for instance in my department alone, family medicine, 110 clinical faculty throughout the State that participate in our teaching, who are not paid. They make that as a contribution to the medical school and the community based hospitals also have—and the community based medical schools I should say, with their hospitals, that is quite frequently the norm.

We went from a 2- to a 4-year degree granting institution in 1976. We did that because we were afraid that if we did not go to a 4-year school—I am a product of the 2-year school and went to North Carolina, Bowman Gray in Winston-Salem. I got back but only 18 to 20 percent of us ever did.

Since we have gone to a 4-year degree granting school we have about 43 or 44 percent of our people coming back. If you were to take a graduate of UND School of Medicine who goes into one of my family practice programs, about 73 percent come back. But I am using North Dakota now just as a model for the community based medical schools.

We have developed within our State something called the North Dakota Center for Graduate Medical Education, which is a consortium of the eight teaching hospitals and the University of North Dakota School of Medicine. On that Board that we have are the CEOs of the eight teaching hospitals, a campus educator from each one of our campuses, and the medical school. And I represent the medical school.

That body is empowered to take a look at the needs of the State, the resources of the State, and act as a conduit for funding from the Federal Government and from other sources that will flow from the consortium into the family practice centers or the other residency training programs. We see that as a model that could be replicated throughout this country.

We also have a P.A. school. As you pointed out, as was mentioned here earlier, Debra Folkerts is an advance nurse practi-

tioner. And our P.A. school has 90 nurse practitioners per class. Those physician assistants come from about 20 to 25 percent from North Dakota, but the remainder come from all sections of the country.

So we feel very strongly about the training of nurses, physician assistants and all other primary care health providers that would take place under health care reform.

Another interesting thing, I think, is the fact that the Inmed Program at the University of North Dakota School of Medicine—Indians into Medicine—20 percent of all the Native Americans that hold the M.D. degree have been trained at the University of North Dakota School of Medicine.

The CHAIRMAN. Is that not interesting? INMED. We will put that in the lexicon.

Dr. JENSEN. INMED—Indians into Medicine.

The CHAIRMAN. Put that down.

Dr. JENSEN. It is a federally funded program.

We feel that more and more teaching is going to take place in an ambulatory setting. So the need for the larger hospitals and the numbers of hospitals that have occurred in previous decades is reduced. More and more care is delivered on an ambulatory care basis and we feel that ambulatory care and training can take place most logically in smaller community hospitals and the tertiary care facilities within our major cities within the State.

Thank you.

[The prepared statement of Dr. Jensen appears in the appendix.]

The CHAIRMAN. You did not run over time, sir. I think we got your point and I think we now start to see if we cannot put this together. When my time comes, I am going to ask you all, how come dentists are kept out of medicine. It is not all just 19th Century happenstance. But that is another matter.

Senator Dole, would you like to have the opening questions, please?

Senator DOLE. I will wait.

The CHAIRMAN. All right, sir. Do not wait long.

Senator Durenberger?

Senator DURENBERGER. Thank you, Mr. Chairman, and thank you for the format. I think it is helpful to our witnesses as it is helpful to us. I assume that means additional commitment of your time, our time later on for other hearings. But it certainly is going to be more productive.

My first question may be directed to all of the panelists, but it came off of looking at Peter's comments. I think they are somewhat repeated by others. I am just quoting from part of the paper here. "There is a clear need for a Federal policy. The distribution of specialists needs to be determined on a national basis to serve national health care needs rather than parochial interests of teaching hospitals" and their training programs certainly endorse that.

I believe the best indicator of market forces at work is the phenomenon described above in the previous comments. The number of specialists being trained is increasing at an extraordinary rate.

Then to varying degrees the first two witnesses come to the conclusion that we need a national work force policy and we need some kind of a process in which to deal with that. That is where

I am going. My question is fairly basic and I ask each of you to respond to it.

If market forces gave us, in a dysfunctional marketplace, many more doctors of a wider variety than we need and not enough emphasis on non-physician health care, at a time when we know that we could do it better and perhaps less expensively with a wider mix of trained professionals, why is it that just changing the signals and changing the incentives, and changing the national rules so that we really have a market at work in this country would not take us where we want to go? Why do we need a national board? Why do we need national allocations, national consortia and so forth?

And maybe just a couple of examples. Someone told me in the last week or so that we are grinding out just as many gastroenterologists as we always have, but not one of them can get a job in the State of California where markets are working—not perfectly but they sure are working. We could on with these type of examples.

The CHAIRMAN. You cannot just leave that there. Is it the climate or the orange——

Senator DURENBERGER. It is the health buying and health providing climate where the emphasis now is on doing better for less money in a variety of ways. The surpluses of specialties which are in the national market, you know, make it impossible for them to get jobs or for that surplus to get soaked up in places like California and Minnesota and other places where there is a fair amount of change taking place in the marketplace.

The second part of that question, of course, gets to the presumption we all make, that all we need to do with the doctor supply is what Canada has done, and that is, half of them are general physicians and half of them are something else, and that ignores the fact that primary care can be delivered by other than M.D.s, and that it is the team or the integrated system that has brought to bear on a particular problem—its diagnosis, its therapy and its rehabilitation.

That is much more important than what you call the doctor that is in charge of the system. And since I have observed, as many of you have, these kinds of responses in integrated systems—and I just use California, Minnesota, Oregon certainly. Last week we used examples here of the difference between Oregon and Florida.

Why do we not just change the rules in health care reform for how the market is supposed to work and then let the market develop the right mix of medical and health specialties?

Dr. BUDETTI. Senator, I would certainly not mean to imply that the market would have no effect. I think that the forces you describe are very real. Some people who are out in the job market right now, either as generalists who are finding a new demand for their services and high salaries, or as specialists as you mentioned who are having difficulty getting jobs, once they get to that point I think that the market for their services does play a very important role and it will determine whether they will go on to practice their specialty or not.

We have been very good at finding ways to practice specialties, whether the market needed us or not, though, I must add.

But I think the question that I would raise, the response that I would have, is principally this, that to the very degree that we think that the market ultimately is going to mean that these people will not get jobs in the specialty that we are training them for, I think we have to seriously question whether we should keep pumping $6 billion a year or so into producing them. I think that is the real issue here.

If that gastroenterologist that you described had achieved the Board certification in gastroenterology entirely at their own expense, that would be a market. But we are paying to produce gastroenterologists and we are paying large amounts of money. We have two parts of Medicare that pump money into training residents in the different specialties.

So I think that is the central issue here, is what is the Federal Government getting for its investment.

The CHAIRMAN. Was it not so that we began by observing that we had perhaps the unintended consequence of building a great many hospitals just after World War II under the Hill-Burton Act, and then came Medicare and that attracted people into the hospitals because the hospitals were there.

Then Medicare began subsidizing particular forms of education. So we have a policy, not necessarily intended. And obviously the Council has been trying to straighten it out.

Senator DURENBERGER. Mr. Chairman?

The CHAIRMAN. Yes.

Senator DURENBERGER. If I may, just in conclusion, and because various people have addressed the issue of graduate medical education reimbursement, back in 1983 when we designed the DRG system we set up 468 diagnosis related groupings and we took into consideration everything other than the indirect subsidies for medical education.

So in other words we were saying, what does it actually cost to provide a particular clinical outcome on the average for 468 processes. Well, if we had stuck with that literally, there would not have been any money from Medicare as a third-party payer to contribute to education.

So Sheila Burke and I, and perhaps some others, but at least two people in this room, started working on how do you account for that. I put out the fact that we could take the $1 billion we were spending on medical education at that time in Medicare and send it back to the States as a block grant. That was the federalist in me or the anti-federalist.

Of course, I got an adverse reaction from all the private medical schools who said the State Legislatures will spend this money in the public schools and it will never get to us.

So after that, we came up with the design of the GME and then the indirect teaching which directs us to some of these other areas. I hear the message now is that what GME is doing because it sort of reimburses hospitals rather than reimburses the professional, what it is doing is giving us what those hospitals want to give us and what those medical centers want to give us, which is super specialists.

So regardless of the response to my question, what I think they are saying to us is we very definitely need to redirect that medical, that GME reimbursement.

The CHAIRMAN. Is that what you are saying?

Dr. BUDETTI. I am certainly saying that.

The CHAIRMAN. Dr. Colwill? Dr. Jensen?

Dr. COLWILL. In a modified way,yes.

Dr. JENSEN. By all means, yes.

The CHAIRMAN. Nurse Folkerts?

Ms. FOLKERTS. I would like to interject that although we may be looking at redistributing funding for medical education, I think one thing that we do need to look at is primary care providers and accessing those providers.

It would seem that we do have an abundance of some physicians. But still we cannot get an adequate number of physicians in rural areas and in the inner cities areas. In the town in Kansas where my parents live, they have been without a physician for 3 years. They are being served solely by non-physician providers.

So we need to look that even though we may have an adequate number of physicians, they may not be where we need them. And the other thing is, with basic health services, do we need to access the most expensive provider or do we need to look at a two-tiered system?

The CHAIRMAN. Should we give Nurse Practitioner Burke an opportunity to be heard? [Laughter.]

Dr. Colwill?

Dr. COLWILL. Yes, I had a couple of comments. Senator Durenberger, I have to say I was where you were at in my own thinking just a few years ago.

But to make it in the marketplace, to make it really desirable to be in primary care, you need to have the physicians in primary care making what the surgeons make. That is not going to happen very soon.

Senator DURENBERGER. It is getting close. A primary care doctor is getting more than surgeons.

Dr. COLWILL. In a few places. At the same time today, the number of trainees in cardiology fellowship programs will we increase total cardiologists by 25 percent.

Senator DURENBERGER. Yes.

The CHAIRMAN. Thank you, Senator Durenberger.

Senator Breaux?

Senator BREAUX. Thank you, Mr. Chairman, and I thank the panel very much for their presentations.

This is a very interesting and very important area that we are talking about, the role of the teaching hospitals. Both the Breaux-Durenberger and the Clinton proposals are very similar in how we treat academic teaching universities and how we try and encourage doctors and practitioners to go to under served areas.

Do any of you have any thoughts—and maybe this is off what you have talked about today—of how do public hospitals, many of which are teaching hospitals, make the transition from where they are now under Medicaid to where they would have to be in order to to compete with private hospitals if everybody has health insurance?

I really do not have an answer to that and maybe it is not the subject of this panel. But we have a very large system of public hospitals, charity hospitals, in Louisiana that have been there since the days of Huey Long.

I am really concerned that they are not going to be in a position to start competing with private hospitals until they upgrade their facilities, which they would be able to do if everybody had private insurance. But it is the chicken or the egg syndrome. They are not going to be able to upgrade unless people come. People will not come unless they upgrade. And these are the primary teaching facilities in our State of Louisiana and I guess maybe so in other areas as well.

Does anybody on the panel have any thoughts about how that might happen or what is likely to happen?

Dr. COLWILL. This is something that I think the academic medical centers can respond to far better than we can. On the other hand, it is interesting for me to see how the Boston City Hospital has been trying to reposition itself to be more responsive to community physicians. It is now in competition with the other hospitals in the community to receive capitated Medicaid payments.

I have heard anecdotally from another hospital where the State has provided major increases in Medicaid payments for obstetrics and that city hospital is thinking about closing its obstetrics unit now because it has not been competitive.

Senator BREAUX. I do not have an answer for the problem. I think it is a very serious problem out there. I do not think anyone has suggested what the solution is and hopefully we will have some more thoughtful discussion on that area.

Suppose Congress in our "wisdom," or lack thereof, makes a determination that the proper mix between general practitioners, primary care physicians and specialists should be 55/45 or 50/50 for that matter. Are we right in telling every teaching hospital that that is also their ratio?

There are a lot of medical schools out there that specialize in the training of oncologists or different types of surgery. They specialize in teaching specialists. Are we to tell them that they have to completely revamp their operations and you have to do 50/50 and if you do not we are going to penalize you by taking money away from your teaching operation? Anybody.

Dr. BUDETTI. Well, Senator, I would be happy to answer that. I think that we have to be very careful in that area. I think that there are hospitals that really ought to be doing substantially different patterns of training than other hospitals.

I think an approach that says let us set the goal at the national level and then let us figure out some sensible way to make sure we get to that endpoint, while making the best use of each hospital's—I should not even say hospital, out of each training program's resources and ability to train people in the different specialties, that that is really what we ought to have our eye on.

There have been different proposals to do that on a regional basis or to do it on a smaller basis. Some proposals would do it at the individual medical school or training program level. But I think that is exactly the kind of area that we need to look very carefully at in order to make sure——

Senator BREAUX. You are saying we need flexibility on this.

Dr. BUDETTI. We need flexibility. I do not think we should avoid putting the places like my alma mater, Columbia University, and Harvard and some of the other schools to the test of seeing what kind of job they can do in training primary care doctors. But I do not think we should undermine their ability to train, if they are the ones who do the best job of it, of training some of the other sophisticated specialists.

So I think everybody ought to be pushed in the direction, but I think the limits need to be flexible enough to allow the job to get done right.

Senator BREAUX. I would agree with that. I think that is very important.

Let me ask a question. It will be an argument between the universities, I guess, and the other people who have programs as opposed to being academic centers. Where should the money go? I mean, does the money go to the schools or does the money go to the programs? There are going to be some programs that are out there that are teaching that are not part of an academic institution.

You know, we all know there is going to be a real battle of who gets the funds for these types of training programs. Can you give me any thoughts on pros and cons of where it should go? Anybody.

Dr. COLWILL. There are several proposals out there as to how to do it. The PPRC has one. The Clinton health plan has another. The COGME has another suggestion with regard to it. The COGME is suggesting that the dollar should go to consortia consisting of teaching hospitals, a medical school, and other organizations that are working in graduate medical education.

Senator BREAUX. Does that limit it to institutions of higher learning or does that allow programs or does it not?

Dr. COLWILL. The consortia would then fund the programs. If you are going to downsize the total numbers of physicians trained—and incidentally, the total number of positions has increased 20 percent in the past 4 years—you have to have some mechanism for doing it.

The COGME feels that this needs to be done, the decisions need to be made at the local level based upon the quality of local programs and based upon the needs of community.

Senator BREAUX. Let me just ask one follow-up question. Do all the programs, the bills that are pending, whether it is Cooper-Breaux or Clinton or what have you, do you all agree with any of them as far as how that issue is handled or are we all wrong in that area?

Dr. JENSEN. I would like to answer that one. I think there ought to be flexibility. In other words, I think if it appears that the best vehicle would be to go directly to the program in some States or areas that should happen.

If it appears that it might be better to go to the consortia or to the medical school, I really think that that should happen. I want to go back——

Senator BREAUX. Each State could be treated maybe a little bit differently depending on their needs?

Dr. JENSEN. Yes. Because we have what is called the North Dakota Center for Graduate Medical Education. It would seem eminently logical that it ought to go to the consortium and in this case basically the medical school is responsible as a conduit, receiving funding.

I would like to go back, however, just momentarily to the previous question that you had asked. In North Dakota, for instance, we have 70 percent of our physicians in primary care, our residency training physicians.

It would seem to me that under a consortium arrangement it would be possible for us, say, to take that extra 20 percent that we have and credit it to some tertiary care university or hospital and allow them to have a percentage of our primary care base or count, if you will. Then we would have the opportunity to wangle some sort of deal where we may be able to preserve a place in an orthopedic specialty or a neurosurgical specialty or something like that.

The consortium gives everybody the opportunity to make the best use of the resources that are there. I think it would be counterproductive for a medical school that is basically tertiary care oriented and does a fine job of producing subspecialists. I do not think they ought to get into the primary care training programs. They do not have the expertise, just like we do not have the expertise to develop a neurosurgical training program.

Senator BREAUX. I thank the panel very much.

Senator PACKWOOD. I wonder, Senator Rockefeller, if we might ask a favor. I am next on the list and then you and Senator Dole. He has to leave at 11:15, if he could go next.

Senator DOLE. I just want to ask a couple of questions of Dr. Budetti. You make no recommendations as to the training or use of non-physician providers and we have already had testimony from a number of rural States here where we rely on nurse practitioners. What can we do to increase their numbers?

Dr. BUDETTI. Thank you, Senator. I think that is a big gap in my testimony that I am glad for you to point out, which is that I am a strong believer in the fact that primary care is a team work approach to delivery of comprehensive services. I am also a firm believer of letting individuals practice up to the level of their training and expertise.

I think that we should do everything we can. One thing is, as we have discussed here, about redirecting funds for graduate medical education is, of course, to make sure there is money going to graduate nursing education as well and to make sure that money flows in a guaranteed fashion, just like it would for training more doctors in different specialties, that it flows to training advanced practice nurses.

Just as we have to think about the different pots of money for training medical students, training physicians in residencies, we have to think about training both nurses towards their first degree and then training advanced practice nurses. We need to make sure there is money for both of those. I think that is an important aspect. That should always be part of the plan.

Senator DOLE. You also talk about putting a cap on the number of residencies, both you and Dr. Colwill. There are a limited number of States that produce the largest number.

The Chairman is not here right now, but I understand that New York State alone trains 15 percent of all residents, 12 percent in New York City alone and 60 percent more than the next largest State, California. I, for one, do not want to tell the Chairman that Kansas is going to gain residents at the expense of New York. So maybe you could explain that.

How are you going to distribute residencies slots? Who is going to make decision with respect to the caps?

Dr. COLWILL. The COGME proposal would suggest that the numbers of physicians be allocated from Washington under guidelines that would be developed by the COGME, that each consortium at the local level, whether in New York or in Kansas, would make decisions about how to allocate positions to each specialty in each institution, based upon the quality of the programs in that institution and based upon the needs that are in the region.

Now how do you deal with New York City? I think——

Senator DOLE. Very carefully in this case.

Dr. COLWILL. Of course. [Laughter.]

We all understand the enormous issues that are there. I think we need to try to separate the issues of graduate medical education from the dollars that are involved and from the service that is needed. If we separate the three of them, we can then try to address the problems separately.

I would anticipate that there would be a drop in New York State as well as in other States in the total number of positions. I know that the Council on Graduate Medical Education in New York State also subscribes to these goals.

Senator DOLE. You also note in your statement that international medical students fill approximately 21 percent of the residencies nationwide. In New York State they fill 42 percent of the residencies. Now if we are going to limit the number, who is going to choose between U.S. graduates and foreign graduates? Who is going to make that determination?

Dr. COLWILL. Well, nobody would. They would compete for the positions. I would anticipate that the best qualified people would get those positions.

Senator DOLE. I want to ask Ms. Folkerts—I appreciate, again, your coming, your testimony. There has been a lot of thought given. You have heard questions from other of my colleagues here the way we reimburse for medical education, moving the funding away from institutions that encourage in-patient versus ambulatory care.

Where do most advanced practice nurses receive their education now? And what is the best way to provide funds that would get to your colleagues, through grants or loans or some other way? And how did you get through yours?

Ms. FOLKERTS. A good question. Basically, with advanced nursing education, nurse practitioners are currently educated in the academic setting. Most of these are at the master's level so those would be in the academic setting.

However, in regard to their preceptorships, many of them go to the rural and inner city areas for their preceptor or their clinical training. When I went to my program, that was in the very early 1980s, there were programs from the universities which went out to the rural areas so that those practitioners could be accessed. I

believe that we know, especially in rural and inner city areas, that if you can take a product from the community and educate them, they are more likely to stay there.

The program that I went to was just for rural practitioners and brought out from the university. The way that I financed my education was with student loans. I solely financed that and we had the burden. Likely, most nurses in advanced practice at this point are on student loans. There are very, very few grants or stipends. Their education is financed solely by themselves or through a scholarship.

Senator DOLE. Grants and stipends go to physicians?

Ms. FOLKERTS. Pardon me?

Senator DOLE. They go to physicians.

Ms. FOLKERTS. Right.

Senator DOLE. Could I just ask one additional question? Is it true that the declining number of physician assistants are choosing primary care as a practice area?

Ms. FOLKERTS. I cannot comment on physician assistants. That is not as much my expertise as nurse practitioners.

Senator DOLE. What about nurse practitioners?

Ms. FOLKERTS. Nurse practitioners choose primary care. Definitely.

Senator DOLE. That stays about the same?

Ms. FOLKERTS. Yes.

Senator DOLE. Could I just ask Dr. Jensen this—and tell Bill John hello for me—where do specialists generally train in North Dakota? Where do your specialists come from?

Dr. JENSEN. In North Dakota our family practice specialty training programs certainly take a large number of our graduates. The internal medicine program. We have a surgery and a psychiatry program. The remainder of the specialty training and subspecialty training must be gained outside of North Dakota.

That is wherein I think a consortium arrangement for our students and ultimately our residents would then go to some other site. We could make arrangements with those types of facilities and medical schools.

Senator DOLE. What you were referring to earlier?

Dr. JENSEN. Earlier, correct.

Senator DOLE. My time has expired. But if the witnesses would not mind, I have some additional questions I would like to submit.

The CHAIRMAN. Of course. Would you take more time, if you have a moment to stay?

Senator DOLE. No, I need to go somewhere.

The CHAIRMAN. Well, of course, we will put those questions in the record.

Senator DOLE. I hate to burden them with additional questions. Thank you.

[The questions appear in the appendix.]

The CHAIRMAN. Senator Packwood?

Senator PACKWOOD. Dr. Jensen, if I might just follow up on the last question Bob Dole asked.

Dr. JENSEN. Yes.

Senator PACKWOOD. You do train your psychiatrists and brain surgeons in-State or do you not have the facilities for that and you send them out of State?

Dr. JENSEN. We do not have the facilities, nor do we plan ever on trying to advance those facilities.

Senator PACKWOOD. No, I think that is very wise.

Dr. JENSEN. Psychiatrists, however, we do have a psychiatry training program. But that has a limited number of residents. I think currently, as I recall, about 12.

Senator PACKWOOD. Is your consortia a legal entity?

Dr. JENSEN. Yes, it is. It is a nonprofit corporation that is vested in the State of North Dakota.

Senator PACKWOOD. Who makes up the consortia?

Dr. JENSEN. Who put it together?

Senator PACKWOOD. Well, who is in it?

Dr. JENSEN. The CEOs of the eight major teaching hospitals in our four campuses, major metropolitan areas in the State.

Senator PACKWOOD. Say that again.

Dr. JENSEN. Eight CEOs of the eight major teaching hospitals in the State of North Dakota, a campus educator from each——

Senator PACKWOOD. I thought you did not have any teaching hospitals. I am confused.

Dr. JENSEN. Well, we consider teaching hospitals our community-based hospitals.

Senator PACKWOOD. Okay. Sort of generalist hospitals as I call them.

Dr. JENSEN. That is absolutely correct.

Senator PACKWOOD. Okay. So they are in it.

Dr. JENSEN. Yes. It is also made up of the four campus educators, one in each of the quadrants of the State; and then I sit as the President and CEO of the organization.

Senator PACKWOOD. And this consortium gets all of the money that the Federal Government gives for any kind of training; is that correct?

Dr. JENSEN. Well, we have had to go back to the hospitals and ask for the funding. Because you will recall that currently both the IMEs and the DMEs come directly to the hospital.

Senator PACKWOOD. Yes. But the hospitals have agreed to let the consortium handle it all?

Dr. JENSEN. Yes, and they have done a pretty good job about that. I must confess, however, that under the Freedom of Information Act, I had to get that information and then present it to the hospitals. When they knew that I knew how many dollars were being put into the hospital, they became much more cooperative.

The CHAIRMAN. Oh, my goodness.

Senator PACKWOOD. I want to ask you what would happen. It seems to me you have handled this problem very well. You are suggesting that as a matter of Federal law we ought to do this Nationwide or maybe do it State-by-State or geographic in some way. But you support the concept of consortiums?

Dr. JENSEN. Oh, very much so.

Senator PACKWOOD. Now, if you are in a State that has a number of major teaching hospitals, New York obviously being one,

they would all have to be in the consortium. I suppose everybody has to be in it that has any significant involvement.

Dr. JENSEN. Yes, they would and I am not sure I know how to draw the lines, particularly in a community or a large city like Philadelphia or New York. There has to be some rational way in which that can be accomplished. But I can only speak now from our State on a statewide basis.

Senator PACKWOOD. I think I will not prolong this. I will address this to the others. Let me ask Ms. Folkerts first. Would you be satisfied with one of these consortia that your profession, and all these you represent—you represent half a dozen today—would get a fair shake out of the kind of consortia that Dr. Jensen describes and Drs. Colwill and Budetti are talking about?

Ms. FOLKERTS. What I would propose is that there would be one work force to look at the need for M.D. programs, advanced practice programs.

Senator PACKWOOD. What do you mean one work force?

Ms. FOLKERTS. Meaning one national work force or Council. You know, what do we need as far as providers? Can we access primary care providers with a lot of the advanced practice nurses which we already have? Do we need more at that level? What is our need? And that group needs to look at all providers of health care.

Senator PACKWOOD. So you are looking at a national group to determine the need; and then these consortia are going to allocate monies to reach that need and allocate it maybe State-by-State or some other method. I am not sure.

But you would be satisfied to live with the consortia, assuming that they were working toward whatever the agreed national needs are. Maybe you divide those up and say North Dakota provides so many and Georgia provides so many. You could live with that.

Ms. FOLKERTS. As long as it was equitable; meaning it was considered with all health care providers, it was not just graduate medical education.

Senator PACKWOOD. No, no, I understand.

Ms. FOLKERTS. All primary care providers were considered, correct.

Senator PACKWOOD. I understand that. Although the national work force may not come out the way you would like it to come out, in which case you are stuck with it.

Ms. FOLKERTS. Exactly.

Senator PACKWOOD. Yes, sir?

Dr. JENSEN. Senator Packwood, though this concept at the North Dakota Center started with the family practice programs within the State the vehicle is there and it is our intent that it should also be the agent or responsible facility or whatever it is in the State to take care of undergraduate medical education, to take care of the needs of the State as far as physician assistants, as nursing and so forth are concerned.

We do not see a reason to replicate this mechanism. What we are going to do is make it broader or more inclusive and to include the primary health care givers within the State.

Senator PACKWOOD. Now, let me go to the two doctors here on the consortia. Now we are in New York or we are in Boston where you have major teaching hospitals. They are part of the consor-

tium, I am assuming, or the Deans of all the teaching hospitals and major hospitals and you have all these community hospitals and we are going to move toward more hopefully general practitioners.

Let us say New York State is a consortium and go State-by-State. Does this consortium then say, the Columbia Presbyterian or NYU, you do very well at training heart surgeons and we are going to have you continue to train the heart surgeons although we are going to have 5,000 fewer residents all toll; and we are not going to really ask you to train general practitioners because that is not your forté. But we are going to cut back your residencies in this State by 700 because we are going to sort of reallocate those to community hospitals. Do I have a rough idea of the way this is going to work?

Dr. COLWILL. I think there are multiple ways that it could work and that possibly could be one. You could also assume that, say, in Philadelphia there would be five consortia each built around a medical school and its affiliated programs and each of those consortia then would meet the overall goals.

So you could do it in multiple different ways. We do not want to define every aspect of each consortium. We think that needs to be defined at the local level.

Senator PACKWOOD. I understand that. But if you have five in Philadelphia, then we are going to have to hassle how much of the Federal money each of the five gets.

Dr. COLWILL. That is right. Any time you reduce the overall funding or overall numbers of positions, you have to develop some means of allocation.

Senator PACKWOOD. Thank you, Mr. Chairman.

The CHAIRMAN. Did I hear ration?

Senator PACKWOOD. Reallocation.

The CHAIRMAN. Reallocation.

Senator Rockefeller?

Senator ROCKEFELLER. Thank you, Mr. Chairman.

Dr. Budetti, one of the things that we have to be obviously sensitive to, as we address work force reform, is the fact that in States like New York, where as Bob Dole says they train 15 percent of all the residents, that there has to be some kind of a transition in order to help support academic health centers and teaching hospitals.

Although this is a problem in many areas, none may be quite as important as New York because of their role in training so many physicians. It is not inconsistent to talk about achieving work force reform and getting to the 55/45 generalist/specialist ratio, if you include OB/GYN, and yet at the same time devising a mechanism of transitional help to protect the academic health centers in New York. Can we do both?

Dr. BUDETTI. Yes, Senator. In fact, I think we will have done it wrong if we do not do both. I think that what we need to do—this gets to the issue of two kinds of transitions that I was talking about before. One is the transition of the training programs themselves, trying to decide nationally what the right balance is and then figuring out what the best way to divvy up that is around the country.

But the other is the transition with respect to service delivery and to make sure that the teaching programs in New York City and throughout New York State, but especially in the city, that are delivering so much service right now, and that exist largely to deliver service, that they be replaced by service delivery entities—doctors, nurses, clinics, whatever it is that it takes to deliver the services—and that we not pull out the teaching programs before we make sure that there is access to adequate health care services, either private offices or clinics or whatever else it is.

I think that in both cases there needs to be a transition. There needs to be money to make sure that the teaching programs survive and continue to be able to do what they do well. But at the same time we need to make sure that there are ways that the people who are just going to those programs for service really could be seen in a private doctor's office or could be seen well outside of the sophisticated teaching program get access to care.

That is money, too. I think in both cases it is money and it is also programs like National Health Service Corps, Community Health Centers and other kinds of entities to set up in the areas where we cannot get mainstream medical care.

So I think we do need to do both at the same time and it probably would take some more money.

Senator ROCKEFELLER. Do you think it will take more money than is currently in the administration bill?

Dr. BUDETTI. I think that is not unreasonable to think about, taking more money, Senator. In particular, there is a couple of year gap where the Medicare payments fall off and the money that would come from setting up the new delivery system is not able to sustain the current levels of outside funding.

So I think that at an absolute minimum that rough transition would need to be smoothed over. And then beyond that I think we need to look real hard at how much money is needed. I think that when we do look at that, there will be some tough questions as to what it does cost to run a teaching program and where the money ought to be going. But I think we need to face up to that.

Senator ROCKEFELLER. I want to read a statement and see if you agree with it. "Today the income at most academic health centers is made up of only 5 percent or less from medical school tuition, even though tuition may be greater than $20,000 a year. Most of the income is now clinical income—from subspecialty procedures in cardiology, gastroenterology, orthopedics, et cetera—and this represents about 40 percent of the total revenue. Research from the NIH and other sources represents another 20 to 30 percent of the revenue, and the remainder comes from State and local governments, especially for State schools."

In other words, virtually nothing comes from the drawing power of the school itself.

Dr. BUDETTI. No matter how you add up the money, there is a lot of public money going in. Just the other day I added it up and it looked to me like you could easily make the statement that more than half of the money going into our medical schools—now we have to be careful to separate the medical schools from the graduate medical education programs—but that more than half of the

budgets was coming one way or another from public sources, including NIH grants.

Senator ROCKEFELLER. Let me read one more statement and see if you agree. "What drives the academic health centers then is dollars. It has to. When the source of funding was in research that is what academic health centers did. When funding became available from third party reimbursement for specialty care, that is were academic health centers shifted. To have power as an individual department, all you need is a research grant or a financially reimbursable clinical skill. "Since the leadership, the Deans, and the Presidents of these academic health centers, do not control these dollars, they have difficulty controlling the direction of the schools." Would you agree with that?

Dr. BUDETTI. I would certainly agree that they are good Americans and they go where the money is. I am not sure what the lines of power are, frankly. But I do think that it is the lines of power. That is what the money argument was all about. Senator Breaux's question about who should get the money and how the consortia, if there is going to be consortia, how they should be structured, that is the heart of the question.

Where is the money going to go? Is it going to get in the hands of the people who are running the programs that we want the money to end up in or does it go to the Department Chairs or the Deans or the heads of the academic health centers into a general pot that they can then do whatever they want to with it? I think that is an essential question.

Senator ROCKEFELLER. I have a question, but my time is up.

The CHAIRMAN. No, no, Senator Rockefeller.

Senator ROCKEFELLER. I can wait.

The CHAIRMAN. We have one panel.

Senator ROCKEFELLER. All right.

So in a sense, there seems to be a real difference, Dr. Budetti, between the kinds of physicians that are needed by the country on the one hand and the number and kinds of physicians that are needed by the teaching hospitals. There may be different requirements, because I think only one out of every 1,000 people go to a university hospital for care in any given month, although 250 of 1,000 people will see a physician in any given month.

So if we continue to decide to train physicians, depending on how many doctors and how many specialists are needed to provide care at our teaching hospitals, we will continue to train a vast over supply of subspecialists, and at an enormous cost to society.

Do you agree?

Dr. BUDETTI. Absolutely. I think that is exactly one of the key points—that we are using public money right now to satisfy the limited, central, very understandable needs of the teaching hospitals rather than the public policy.

I think that we should not expect them to do any different. If we are laying the money out there, they are going to behave in the way that best serves their interests.

Senator ROCKEFELLER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Rockefeller.

Senator Grassley?

Senator GRASSLEY. Thank you, Mr. Chairman.

Dr. Jensen, you stated that 55 percent of your people are in primary care. I think you indicated you do a pretty good job of keeping them in your State. I guess my question is, since that is so out of the ordinary, to explain how you do it and is it as good as what you indicated. And particularly, what is it that keeps them within your State if I interpreted that right?

Dr. JENSEN. The weather. [Laughter.]

Senator GRASSLEY. Before you answer, I might say that in my State of Iowa, in the 1960s we had our professors at the University of Iowa—this would be 30 years ago now; hopefully, it is not this way now—you know, advising people, you know, go to California. That is where the big money is in medicine.

So that kind of hurt our retention. Then we had various proposals made to the Legislature that if we would set up a Department of Family Practice and have a specialty in that, that would help the situation where the snobbery of medicine got people into specialties because there was something about general practice that was not quite as good as it should be, so that would raise the level of that profession or that subspecialty.

And then later on in the middle 1970s, because I was chairman of the Appropriations Committee at that particular time, they said, well, just create some family practice residency programs around the State. So we created eight of those. And if you get them to do their residency in Iowa in family practice, the statistics show they will stay within 50 or 60 miles of there.

I do not know whether those things work or not. But we spent the money and we are still doing it in all those respects. Is there any aspect of that that you use as well? Incorporate that into the answer to your question.

Dr. JENSEN. Well, the answer is many fold, Senator Grassley. When I became the Chair we undertook a cohesive, coordinated effort to attract our students into family practice. Item number one in the discipline. We think that family practice and primary care are essential. We think that they practice excellent medicine which is cost effective.

We also have on our Admissions Committee of 11 about 5 primary care physicians, of which 4 are family physicians. We select students who are just primarily within the State as our candidate for applicant pool for the University of North Dakota School of Medicine.

We have family practice well represented throughout the first 2 years or the academic aspect in the classroom situation, with family physicians as lecturers. We have at the end of the second year our students go to community hospitals—27 community hospitals throughout the State to spend a 3-week period.

We have in my discipline anyway 110 family physicians around the State and we require each and every one of our senior medical students to go out to those sites to take an 8-week rotation. Then we bring them back to the community hospitals at the end of the fourth year, just prior to going into the residency training programs. They act as residents or subinterns in those community hospitals where they were at the end of the second year. The curriculum is in this document.

We feel that in the proper setting and proper climate and having obvious pride in the discipline of family medicine that we can attract our people into family practice.

When I went through the 2-year school—North Dakota then was a 2-year school—only 18 to 20 percent of us ever got back to the State of North Dakota. Since we have granted the M.D. degree in 1976 we have about 43 to 44 percent total that ultimately come back to the State to practice, recognizing many go out for obstetrical training programs, neurosurgical programs and so forth.

If you were to take a graduate of the University of North Dakota School of Medicine who goes through one of the family practice programs, 73 percent stay within either the State or the immediately adjacent territory as we mentioned earlier with Senator Durenberger.

I think it is a commitment to primary care. It is a philosophy, if you will, and it is a mission.

Senator GRASSLEY. And I suppose that your point is that not enough schools have that primary purpose and that respect for family practice and the promotion of it that causes necessity to get the Federal Government involved in making some determination of the amount of family practitioners we have.

Dr. JENSEN. I am not sure just exactly what you mean by that.

Senator GRASSLEY. Well, you have done it without the intervention of the Federal Government obviously.

Dr. JENSEN. Yes.

Senator GRASSLEY. And obviously other medical schools, presumably because they have less emphasis upon primary care, do not produce as many family practitioners and that is what has brought us to the point of meeting a political determination of how much more primary care we need.

Dr. JENSEN. You are absolutely correct. It just strikes me that the Federal dollars have to go into primary care training programs. And it might even be necessary to put in some sort of stimulus, in other words to support family practice resident programs at a higher level than some of the other programs, if that would appear to be necessary.

Senator GRASSLEY. I will just ask one question, please, of Ms. Folkerts.

The CHAIRMAN. Please, Senator.

Senator GRASSLEY. I wanted to thank you for mentioning the bill that Senator Conrad and I put in. But more importantly, how do you see nurses and nurse practitioners functioning under managed care programs?

Ms. FOLKERTS. Nurse practitioners are trained to provide basic primary care. I see nurse practitioners as being perhaps the first level of care in a primary care setting. Meaning, when a patient comes in with a sore throat, elevated temperature, at that level they need primary care.

At that level, nurse practitioners are very cost effective in providing the care that is needed. If the patient does not respond or his or her needs become more critical, then in a managed care setting I see accessing the physician level.

In other words, using physicians in the cases in which their expertise is needed and using nurse practitioners' expertise in the basic health primary care services. They would work as a team.

Senator GRASSLEY. Thank you, Ms. Folkerts.

The CHAIRMAN. Fair enough. Thank you, Senator Grassley.

Senator Conrad?

Senator CONRAD. Thank you, Mr. Chairman. I thank all of the members of this panel as well. I think this has been a good morning.

Let me ask Dr. Jensen first if I might—and I should tell my panel members that Dr. Jensen was actually the personal physician for our State's Congressman when he was growing up in Valley City, ND. So when he talks, we listen.

Dr. Jensen, at the University of North Dakota we have accomplished what is rapidly becoming a national goal, that is to try to get more than 50 percent of our doctors who are in training to focus on primary care. That is clearly emerging as a consensus national goal.

In terms of accomplishing that, you are at 55 percent at the University of North Dakota. What would you say are the most important lessons to be learned at a national level if we are to adopt that goal nationally in order to achieve it?

Dr. JENSEN. Boy, you are asking me to put everything into one little capsule. I am not sure I can do that, Senator Conrad. I think there has to be a national goal toward increasing the number of primary care physicians. Yes, we have become a model. We have a State-wide consortium that fits all into that concept. And we have obviously a commitment to family care and family medicine particularly.

In order to get the job done, in order to deliver cost effective medicine in my opinion in this country, we are going to have to rely more on primary care people. That includes, as was pointed out here by Debra, it is going to be nurse practitioners, it is going to be physician assistants and it is going to be a large, large cadre of primary care physicians in this country.

Senator CONRAD. To actually accomplish it nationally, what do you see as the key hurdles? What are the things in the system that prevent us from producing that kind of percentage of primary care doctors? Is it financial disincentives that are in the system, financial incentives that are in the system? Is it a mind set that is out there that the specialty doctors are a higher priority? What is the culture that is in the medical system?

Dr. JENSEN. It is all those that you alluded to. There is no question about the fact that in the medical hierarchy primary care physicians are not up as far on the totem pole as the other super specialties like neurosurgery. There is no question about it. I think it is an attitude in part. I think it is also the fact that Federal funding has been directed to the subspecialty producing institutions preferentially; and I think that has to turn around.

Senator CONRAD. All right. Maybe if I could ask each of the witnesses, as you look at this whole issue of graduate medical education and you see the plans coming forward, could you tell me, what is the thing that strikes you as the single most important message you would want to leave this committee with? I mean, if

you were to distill the message that this committee ought to absorb today, what would it be? Dr. Budetti?

Dr. BUDETTI. I think for me, Senator, the single most important message is that if you do not do anything at all, you are doing a lot. And it is to continue the policies that are already in place and sending large amounts of money and we are going to continue to produce the kinds of imbalances that we have seen so far.

For number one it would be, do not think of leaving things alone as leaving things alone. It is leaving in place policies that are going in the wrong direction. Number two, what I mentioned before, try to separate out the need to deliver services properly to people which national health insurance ought to accomplish, from the need to make sure the training programs do what they are supposed to do, which is produce trainees.

Senator CONRAD. All right. Doctor?

Dr. COLWILL. I think Dr. Budetti said it all. I would add only one other piece. Today we have the possibility of modifying graduate medical education to prepare the doctors which the Nation needs.

Senator CONRAD. All right.

Ms. FOLKERTS. I would ask that nursing graduate education be continued with a directed revenue source so that nursing may provide and assist with the primary health care needs of the United States in providing primary care.

Senator CONRAD. Dr. Jensen, what would be the message, the single most important message you think the committee should learn from this panel this morning? If you had to distill that message into a few sentences, what would it be?

Dr. JENSEN. Well, I think it would be to redirect the funding from the tertiary based medical schools that have historically produced an oversupply of super specialists and redirect it to the primary care training programs within the country.

Senator CONRAD. Maybe I could ask you, when you use the term the "tertiary care facilities," what do you mean by that?

Dr. JENSEN. Well, I am talking about those institutions that primarily produce cardiologists, cardiovascular surgeons, neurosurgeons, et cetera, et cetera. We are seeing certainly an oversupply of those types of subspecialties in this country.

Senator CONRAD. If we had those people that represent those subspecialties here today, would they agree with that characterization?

Dr. JENSEN. Well, I am not sure that they would. [Laughter.]

But I think it is because they would not agree because they have a vested interest.

Senator CONRAD. All right. I thank the Chairman. I thank the panel.

The CHAIRMAN. I thank Senator Conrad.

Dr. Jensen, you would not mind my suggesting that they have a vested interest in the advancement of science.

Dr. JENSEN. There is certainly no question about that and that did not mean to imply that they did not have. Certainly many of the true and great significant findings have taken place in these institutions. That is the reason I feel that they ought to be doing precisely what they are doing, but to a lesser degree, and redirecting those funds.

I also think very strongly that there is a tremendous body of primary care research problems that need to be identified and remedied. That is where I think the—I pointed out earlier I was in support of and speaking really for the community based medical schools. We feel that we are the schools that would be able to direct our attention toward primary care research problems and be responsible for determining outcomes, which is terribly important.

The CHAIRMAN. I thank you, doctors all.

Senator Daschle?

Senator DASCHLE. Thank you, Mr. Chairman.

I'd like to take this opportunity to summarize what appears to be an extraordinarily helpful hearing, and also to consider the many excellent statements already given by the witnesses. Senator Conrad, with his questions, summed up much of what I had intended to address.

Dr. Budetti, I was particularly impressed by your last remark, which properly describes the debate about all of health care reform not just GME. Unfortunately, there are people who still believe that doing nothing is somehow the most benign, the least detrimental course of action.

I think that, among all our options, doing nothing could have the most detrimental consequences. I wish more people were here when you said that yourself.

Witnesses, thank you for your references earlier to some of the legislation we have worked on. You mentioned just a moment ago that a delineated funding stream was crucial to the role that nurse practitioners can play in future primary care allocation. Could you elaborate a little bit more about why a funding stream is important and how you would implement it?

Ms. FOLKERTS. With education, as I had stated, nurse practitioners are currently left to bear the burden of their education alone. There is no directed revenue source to help with graduate nurse education that does not undergo yearly review to provide funding.

We have 6,000 advanced practice nurses currently who cannot get into programs that are wanting to provide primary care. And to have that funding available to provide for graduate nurse education would be a great benefit to nursing, to help provide for the primary care needs of the country.

Senator DASCHLE. Is it accurate to say that were you to fail to achieve some delineated funding stream that the future plight of nurse practitioners would be like the one they face today, where the medical community is not able to make full use of their potential as providers of primary care?

Ms. FOLKERTS. Absolutely.

Senator DASCHLE. Senator Conrad asked the question that I was thinking of asking all of you. I would like each of you to propose an action plan that you think we need to consider, regardless of which plan ultimately may come out of this committee.

What specific pieces related to GME are essential if we are going to convert our over-reliance on subspecialists to a greater reliance on primary care practitioners?

The impression I have from your testimony so far is that the key issue is a delineated funding stream. If we fail there, we probably will have failed to provide the opportunities necessary to reach the

goals set out in the Clinton plan. But is there more to it, and if so, what? Dr. Budetti?

Dr. BUDETTI. Yes, Senator. Just to be clear, we are not just talking about medical schools. We are talking about the entire spectrum of where the training takes place after the medical schools produce physicians. That would be both the hospitals, and what we would like to see expand, the community based and ambulatory care settings, in which primary care trainees need to do their training.

So I would say that the first thing is to set as a national policy that we do want to put money into making sure that the future work force that the health professionals of this country meet the needs of the future, number one. That would mean that we would require all payers to contribute equally and not just Medicare and ad hoc from private sources.

And number two, establish a process like setting up the national commission that is described in several of the bills, that would lay out, as Dr. Colwill has described, for the existing Council, the national policy and what the goals were and then tie the two together. Say the money is only going to be spent if it pursues these national policies.

Then step number three, let us figure out a way of divvying up the money to meet these policies. That is a complicated phase of implementation, but it is not something that I think is impossible to achieve.

Senator DASCHLE. Dr. Colwill?

Dr. COLWILL. I think there is a dual goal. One is to have adequate numbers of generalists. I think Dr. Jensen talked eloquently on that and I have spent the last 22 years of my life doing similar things.

Secondly, we need to find ways of reducing the number of specialists educated. Those come hand-in-hand. If you do one without the other, you are not going to get the job done.

Senator DASCHLE. Ms. Folkerts, do you have anything to add to that?

Ms. FOLKERTS. Approximately 70 percent of all nurses in advanced practice currently are providing primary care. So nursing is not affected by this shift to primary care because we are already doing it. What we need is the graduate nurse education funding to enable us to do it even better.

Senator DASCHLE. Thank you. Dr. Jensen?

Dr. JENSEN. Yes. I would suggest as Dr. Budetti has that it should be an all payer system. I do not think there is any question about that. I think it is unfortunate that currently it is just tied to the Medicare system. We are talking about a change in the work force and essentially a national policy. I do not see that that should be limited just to the Medicare system. That does not seem logical or rational to me anyway.

The other thing is that I think it is important that you maintain flexibility because a State like North Dakota with its State boundaries and with its make up of the medical school and the use of our community facilities is considerably different than in Philadelphia or New York certainly.

I think that you ought to maintain the flexibility in there to make sure that the monies do come ultimately, primarily directed back now appropriately to the primary care programs within the country. That can occur within a consortium in a medical school, in alliances, and hospitals joining those. And they may assume as many different forms as essentially there are States. So I think that is terribly important. I guess that is basically my advice.

Senator DASCHLE. Well, thank you all for your answers.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Daschle.

We do, indeed, thank you. You can see the field of response here from the Senators.

I guess what I would find myself interested in is the degree to which—Dr. Budetti, you began the subject and then each of you added to it—we have in place unacknowledged policies which have consequences, which can be shown to be related to what we do, even if we have not decided that is what we want to do. That is something you find in government. It is a very common tradition. If you wanted to supplement any of your statements in writing by giving us an example there, we would appreciate it.

I wish someone just once would address the subject of dentistry. [Laughter.]

Surely it is pure accident that dental schools and medical schools developed separately in the 19th Century; is it not? I mean, are teeth not part of the body? Do you not let medical students look inside the mouth?

Dr. BUDETTI. Senator, that is a tough question. Why we have podiatry separate from medicine, focusing on one part, the other end of the body.

The CHAIRMAN. There are historical reasons.

Dr. BUDETTI. There are historical reasons why we are there. It may also be everybody's natural aversion to the work of dentists I suppose.

The CHAIRMAN. Well, then all the more the calling should be honored.

Dr. BUDETTI. Absolutely.

The CHAIRMAN. To take a life in which people avoid you. I have given enough commencement addresses and have sat on enough platforms on which the Dean of the Medical School, the Dean of the Dental School said, oh, we are going to be merging any day now. I first heard that 30 years ago. It calls for some attention. I would just leave it to you. It is curious to me that it is not attended.

The other thing is just to say for the record, that the advancement of science is a great national undertaking. I think we are in the heroic age of discovery. Much of the beginning of this century was the heroic age of physics. We got to the bottom of the matter you might say. All was done in Europe. Americans just watched it.

Now this age of medical discovery is in the main happening here. That is a change in the culture. Once you learn these things you learn them for all time. America, the United States, is doing this for the rest of the world.

I am told, and I do not know how to judge something like this, that the advent of universal health care systems has had a suppressing effect on medical research in Europe. I do not know how

you would count up the papers and references. There are ways to measure science, who gets cited.

Maybe the last great event was the discovery of DNA at Cambridge. I cannot think of anything else, but then I do not know the field that well. If that were so, that is a question that needs to be asked. Government policies have obviously facilitated what was going to come anyway, I think. It was our turn, as it were.

It was 250 years ago that Benjamin Franklin established the American Philosophical Society for the advancement of useful knowledge. I happen to be a member. We observed the transit of Venus in 1760. It was the first American science noted in Europe, before the American Association for the Advancement of Science, the American Academy of Arts and Sciences in Cambridge.

Something makes me uneasy about government deciding what people should do on the edges of knowledge. The government will not know. I am appalled when I read about people who want more research in this or that in X and Y university. I mean, research will be done by people who want to do it.

In these great days we have let people follow their own directions and extraordinary things have happened. I am just musing here, but you follow perhaps what I am saying. I cannot imagine anybody walking in a room and telling an economist what he should study. You do not know that. You can get pretty mediocre departments that way and the best ones will leave you and go to Toronto where they will be allowed to do what they want to do, which is another thought.

But the hour of noon having arrived and our party caucuses taking place, we want to thank you most sincerely. Do give us, if you have a moment, and obviously this is your field, Dr. Budetti, and, Dr. Colwill, you obviously are working at it, some idea of where you think the hidden policies are. It would be nice to know how much influence Hill-Burton had on the development of all those things.

A wonderful subject, beautifully elaborated. You can tell how much we are grateful to each and all of you.

Dr. BUDETTI. Thank you, Mr. Chairman.

Dr. COLWILL. Thank you.

The CHAIRMAN. The hearing is adjourned.

[Whereupon, at 12:00 p.m., the hearing was adjourned.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED

PREPARED STATEMENT OF PETER P. BUDETTI

Mr. Chairman, Members of the Committee. I am Dr. Peter Budetti, the Director and Founder of the Center for Health Policy Research at The George Washington University. I hold an endowed chair as the Harold and Jane Hirsh Professor of Health Care Law and Policy, and serve as a full-time tenured faculty member in the Department of Health Services Management and Policy, School of Business and Public Management. I also have joint appointments as Professor of Law in the National Law Center and Professor of Health Care Sciences in the School of Medicine and Health Sciences.

Mr. Chairman, my training is as both a Pediatrician and lawyer. A displaced New Yorker, I earned my medical degree from Columbia University College of Physicians and Surgeons. After being trained in pediatrics, I studied law at the School of Law (Boalt Hall), University of California, Berkeley. My undergraduate degree was awarded magna cum laude from the University of Notre Dame.

I am and have been Principal Investigator on a range of extramural funded projects and have published a number of articles on workforce policies such as we are discussing today. Between 1978–84, I served on the national Committee on Pediatric Manpower of the American Academy of Pediatrics. As Chair of that committee between 1982–84, I worked closely with members and staff of the Academy to develop data and analysis on the need for training pediatricians.

Between 1984 and 1990, I served on the other side of Capitol Hill as Counsel to the Subcommittee on Health and the Environment of the Committee on Energy and Commerce. I was the professional staff member with primary responsibility for legislation and policy concerning health insurance reform, health professions education, and a number of related areas. This past year I was called upon to serve as a member of the core legislative drafting group for President Clinton's Health Security Act.

From 1975 through 1984 I was with the Institute for Health Policy Studies, School of Medicine, University of California, San Francisco, leaving as Associate Professor-in-Residence of Social Medicine in Pediatrics. As Assistant Director of the Joint Medical Program of the University of California at Berkeley and San Francisco in 1982-84, I was deeply involved in issues of medical education.

Mr. Chairman, as someone who has spent many years deeply involved in this issue, I very much appreciate the opportunity to discuss my personal thoughts on the restructuring of our health professional workforce with you. I would emphasize that I am here to present my own views, and I am not speaking on behalf of the Administration, The George Washington University, the American Academy of Pediatrics, or anyone else. Because I recognize well your time constraints, I ask that my full written statement be included in the Record of this hearing, and I will make only a few particular comments here today.

Mr. Chairman, I believe that six main points should be emphasized with respect to the need for federal action in shaping the future supply and distribution of health professionals. *First*, there is a serious imbalance of health professionals, with far too many in specialties other than primary care. This imbalance is costly in economic terms, inappropriate in medical care terms, and escalating rapidly. *Second*, this excess supply of practitioners in specialties and subspecialties is not merely a product of market forces at work. To a very large degree it is an unintended and counterproductive effect of certain existing federal policies. As a result, without new federal initiatives to reverse these perverse consequences, those federal policies will continue to exacerbate the situation. *Third*, even modifying current federal policies would not be sufficient. Federal action to limit growth in nonprimary care special-

ties is needed to assure that we have an appropriate health care workforce in the future—neither the current market forces nor foreseeable changes in the health care market will produce the mix of practitioners necessary to serve patient care needs. *Fourth*, federal action will be effective and need not be overly intrusive or heavy-handed. While there will be inevitable transitional problems, these can be minimized. *Fifth*, health care reform presents a unique opportunity to reduce the need for many people in the inner-city to go to large teaching hospitals and clinics for their medical care, and to redirect specialty training at the same time. Universal coverage will provide new opportunities for everyone to receive mainstream medical care, and new challenges to teaching programs to broaden clinical teaching beyond the traditional population of low-income individuals. *Sixth*, health care reform itself could well be jeopardized by failing to reform the workforce. Continued growth in the number of inappropriately trained specialists will create an ever-larger cadre of health professionals who would feel threatened by and work to defeat comprehensive health care reform.

First, there is a serious imbalance of health professionals, with far too many specialties other than primary care. This imbalance is costly in economic terms, inappropriate in medical care terms, and escalating rapidly. Insufficient numbers of primary care practitioners are available for deployment where they are needed most, while highly specialized physicians proliferate and dominate medical care practice and spending patterns. The proportion of physicians in family medicine, general internal medicine, and general pediatrics has fallen precipitously as the number in other specialties has skyrocketed. In 1931 about 87 percent of U.S. physicians were engaged in primary care; by 1970 the share was reduced to 38 percent, and by 1990 to 31 percent. When obstetrician-gynecologists are added in, the total is just under 36 percent. (Figure 1)

The Association of American Medical Colleges reports that between 1982 and 1993 the proportion of graduating medical students planning to become board-certified in Family Medicine fell from 15.5 percent to 11.8 percent, in General Internal Medicine from 14.4 percent to 4.5 percent and in General Pediatrics from 6.2 percent to 3.0 percent. (Figure 2) Overall plans to enter those general specialties fell correspondingly, from 36.1 percent in 1982 to 19.3 percent in 1993.(Figure 3) Even after a small rebound from historic low rates in 1992, the 1993 figures still show that nearly 50 percent fewer graduates foresee careers in primary care than a decade ago.

While fewer students are going into primary care, there has been an expansion of residency positions in nonprimary care specialties that is nothing short of staggering. In 1988, there were under 85,000 physicians (M.D. and D.O.) in residency training; by 1992, there were over 101,000—a 19 percent increase in only four years.

Barely one-fourth of that expansion has been in primary care and obstetrics-gynecology; the bulk of it has been in the other specialties and subspecialties. Between 1988 and 1992, the number of trainees in medical subspecialties grew by over 60 percent, and in other specialties by 28 percent. Cardiology expanded by 50 percent, Pulmonology by 65 percent, Gastroenterology by 45 percent, and other medical specialties by 69 percent. In contrast, primary care residents increased by just under 1 1 percent, as did surgical specialists. (Figure 4)

Mr. Chairman, the pipeline of specialists and subspecialists in training that was already glutted is now threatening to burst at its seams.

Second, this excess supply of practitioners in specialties and subspecialties is not merely a product of market forces at work. To a very large degree it is an unintended and counterproductive effect of certain existing federal policies. As a result, without new federal initiatives to reverse these perverse consequences, those federal policies will continue to exacerbate the situation. Federal policies designed for other purposes have had the unintended and unfortunate effect of creating a climate in medical education that is not hospitable to the production of an adequate number of primary care practitioners and that rewards expansion of positions in other specialties. These policies include: generous funding for Graduate Medical Education (GME) through Medicare and, in some states, Medicaid; Medicare's payment policies for hospital and physician services; and, support for a vast expansion of biomedical research in academic health centers and teaching hospitals.

Although nominally neutral on the distribution of residents among specialties, Medicare's GME payments in reality strongly encourage non-primary care physician specialization. They do so in part because they focus nearly exclusively on hospital-based training, cutting off the development of training sites needed for primary care experiences. Training in teaching hospitals is centered on severely ill patients receiving the latest in high-technology medical care. While such experiences are critically necessary for a broad, modern medical education,they are not adequate for

learning the skills and developing the practice style necessary to practice sophisticated primary care.

In addition, Medicare pays for graduate medical education at a level and in ways that create incentives for hospitals to train large number of physicians in highly specialized fields. Medicare's hospital- and physician-payment policies work hand-in-hand with the way that GME payments are made to encourage hospitals to emphasize non-primary care specialties. Under Medicare's hospital-payment policies, specialist residents and fellows help generate far greater patient-care revenues than do primary care residents. This not only encourages teaching hospitals to favor specialties that treat the most profitable DRGs, but also provides a highly lucrative bonus by multiplying the DRG payments more and more as hospitals add residents.

Medicare's GME payments have become a major source of revenue for teaching hospitals. In 1993 Medicare GME payments were projected to be $5.5 billion. In contrast, federal grant programs to support all primary care physician training were some $64 million.

While primary care programs struggled, other specialties benefited from far greater funds from Medicare in payments for direct and indirect graduate medical education costs. The stated rationale for Medicare's GME payments is to compensate for costs borne by educational programs that are not paid for by patient care revenues. That rationale would apply equally to the ambulatory care training sites central to primary care as to teaching hospitals, but federal policy generally has been not to pay primary care sites directly for their GME costs. Hospitals can receive GME payments when their residents rotate through primary care sites, but the sites are not paid for the costs of their own trainees. Non-hospital-based primary care programs are generally not eligible for GME payments, although in a few cases like the Federally Qualified Health Center program, direct medical education costs are allowable. As a result, primary care programs have been greatly restricted in their ability to develop outside of hospitals.

The incentives for hospitals to have large house staffs are particularly striking for Medicare's indirect GME payments. Indirect costs are those that cannot be measured directly, such as extra demands on staff, as well as tests and procedures ordered for learning purposes. They also include costs attributed to the increased severity of illness of teaching patients, even though those are also addressed by other adjustments to hospitals under Medicare's prospective payment system (PPS).[1]

The complicated indirect GME formula increases diagnosis-related group (DRG) payments as the hospital adds interns and residents. For example, a hospital with a ratio of 0.26 interns and residents per bed has its DRG payments increased by 18.54 percent. On average, this amounts to about $2000 per Medicare discharge in the major teaching hospitals. Those 230 hospitals were expected to receive about $9989 in PPS payments per DRG in 1993 with the indirect GME adjustment, some 26 percent more than the $7901 they would have received without it.

Indirect GME payments to hospitals were about $3.3 billion for fiscal year 1993; under current law, they are projected to reach $4.14 billion in fiscal year 1994, and $4.48 billion in 1995. Putting the magnitude of these payments in perspective, the indirect GME payments to only seven big teaching hospitals, which average about $9 million each, equal the entire appropriation for primary care training programs.

"Direct" GME costs are measurable ones such as house staff and faculty salaries. Unlike the DRG multiplier used for indirect payments, direct GME pays hospitals a certain amount per resident, based on their historical costs inflated to the present and their proportion of Medicare patient days. The grand total for direct GME is projected to reach $1.8 billion in fiscal year 1994, and about the same in 1995.

For many years, Medicare paid direct costs without regard to the specialty or length of resident training. In the mid-1980s a provision was adopted that limits payments for residents beyond an "initial residency period." That change, albeit a modest one, represented a recognition on the part of the Congress that a shift in federal policy in the direction of primary care was needed.

GME payments interact with Medicare's hospital and physician payment policies to encourage hospitals to emphasize non-primary care specialties. Hospital payments under PPS help specialist residents generate far greater patient care revenues than primary care residents. While every hospital has strong incentives to favor specialties that treat the most lucrative DRGs, the teaching hospitals have the added incentive of the indirect GME multiplier. With GME payments ostensibly blind to a hospital's specialty distribution, residency programs can be tailored to make it attractive for specialists to bring their patients to the teaching hospital.

In sum, Medicare's GME payments have created strong financial incentives for hospital-based training and the growth of large physician house staffs.

Finally, the emphasis on biomedical research has produced a generation of students who have rarely seen primary care researchers, particularly not ones in posi-

tions of prominence. Instead, these students have been impressed by the complexities, stature, and potential funding for biomedical research. As a result, many think that primary care concerns such as treating chronic conditions among the elderly or common low-back pain are less intellectually challenging and less important than life-or-death problems such as heart disease and cancer.

In 1940 total funds for biomedical research had been estimated at $45 million; by 1987 they had risen to $16.2 billion. In contrast, primary care research has languished. Federal biomedical research support is well over $10 billion while that for primary care is well under $100 million. Lacking in funds, primary care researchers are far less numerous or visible to students and generally not found in prestigious positions within health professional schools.

Each of the existing federal policies noted above needs to be modified or counterbalanced if the educational setting is to encourage primary care. Failing to change these federal policies is not a neutral position; such failure is an action that will continue to use federal dollars to subsidize and encourage ever greater-specialization.

The Congress has addressed these issues in the past, and now has the opportunity to include comprehensive measures in health reform. In particular, a complete revision of the approach to paying for graduate medical education is central to this strategy. Encouraging primary care will require that payments be made for training in the ambulatory-care sites, not just for intensive high-technology care in teaching hospitals. Payments should not reward expansion of the number of highly specialized residents. And, additional support to develop primary care research is needed to enhance knowledge in the field and attract the best and brightest students.

Third, even modifying current federal policies would not be sufficient. Federal action to limit growth in nonprimary care specialties is needed to assure that we have an appropriate health care workforce in the future—neither the current market forces nor foreseeable changes in the health care market will produce the mix of practitioners necessary to serve patient care needs. The first federal attempt to rely on a market approach was to increase the overall supply of physicians with the assumption that a sufficient portion would be primary care generalists. Beginning in the 1960s, the U.S. did succeed in increasing overall supply: medical school first-year enrollments rose from 8,483 in 1961 to 15,998 in 1990. Moreover, International Medical Graduates entered the country in large numbers. Unfortunately, while the overall physician-population ratio nearly doubled (figure 5), the proportion of primary care practitioners decreased.

Much of the expansion of highly specialized medical practice during that earlier period was made possible by the type of health insurance coverage that most Americans had, indemnity plans that paid on a fee-for-service basis. In recent years, more and more Americans have had their coverage changed to a wide array of managed care plans—HMOs, PPOs, and other arrangements that limit utilization and specialty referrals. Some group- and staff-model HMOs that employ their own doctors or otherwise limit the number of physicians available to subscribers now report a shortage of available primary care practitioners. In response, these HMOs have put together aggressive recruiting packages, including high initial salaries for new graduates of primary care residencies. Other managed care entities are buying up established primary care medical practices at a rapid rate.

These developments have led some to suggest that the private sector will modify the training of specialists on its own in response to these changing market forces. As a result, they argue, federal intervention will not be necessary. Unfortunately, that optimistic view fails to consider the most important factors that determine the rate of production of nonprimary care specialists—the financial and professional self-interests of teaching hospitals and training programs.

Anecdotal reports about developments in the job market for primary care practitioners are unlikely to have a substantial effect on clinical program directors in teaching hospitals who work to maintain the size of their residency programs at nearly all costs. Nor will they deter hospital administrators who rely on specialty services to generate revenues. The specialty societies and boards themselves have been extremely reluctant to introduce restrictions on their numbers, in part out of antitrust concerns. Third- and fourth-year medical students who have been impressed with the high status and lucrative financial prospects of the high-technology specialties—and who are counting on high earnings to pay their medical school debts—will continue to respond to those forces.

Moreover, even if changes in the market for physician services due to expansions in managed care were to influence the residency training market, the process would take so long that far greater excess numbers of specialists would be trained in the meantime. Enrollment in group and staff model HMOs and other relatively tightly

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managed care plans cannot suddenly replace indemnity fee-for-service coverage overnight. It could well take five to ten years to get most people into such plans. Many parts of the country do not lend themselves to the urban large HMO model, and many consumers would resist such a trend. Financial rewards for nonprimary care specialties will continue for the foreseeable future, even under health reform.

Recognizing the need for public intervention into the training of specialists, some states have taken measures to affect the distribution of trainees. These measures can only affect what goes on within state borders, however, and will have little overall effect.

If growth in primary care is to be enhanced and in nonprimary care specialties is to be restricted, there is a clear need for new federal policy. The distribution of specialists needs to be determined on a national basis, to serve national health care needs rather than the parochial interests of teaching hospitals and their training programs. The American College of Physicians (ACP), in its proposal for national health reform, recognized the interaction of graduate medical education payments with other factors in influencing the supply of generalist physicians.[2] The ACP also called for regulatory controls on physician supply and distribution.

Mr. Chairman, I believe that the best indicator of market forces at work is the phenomenon described above: the number of specialists being trained is increasing at an extraordinary rate. This enormous growth of specialty training has taken place even as managed care has been growing at a similarly impressive rate. Further delays in taking action will only mean that the baseline is that much more skewed, and that many more professional lives will be disrupted. I believe it is necessary to establish clear federal policies concerning the appropriate distribution of specialists for the future, and to assure that those policies are implemented effectively.

Fourth, federal action will be effective and need not be overly intrusive or heavy-handed. While there will be inevitable transitional problems, these can be minimized. The federal government can take steps that will effectively redirect the training of specialists. Although substantial work needs to be done to develop the best implementation strategies, the time for further study of the problem has long since passed. It has been some two decades since the federal Graduate Medical Education National Advisory Committee (GMENAC) was established. In 1980 that advisory body forecast overall and specialty physician surpluses. In response, federal legislation created an advisory body, the Council on Graduate Medical Education (COGME), which has continued to study and monitor the situation but has had little impact on physician supply and distribution in the face of countervailing federal policies and private incentives. Under Dr. Philip Lee's leadership, the Congressional Physician Payment Review Commission began its ongoing analysis of strategies for modifying physician specialization, and the Office of the Assistant Secretary for Health now has a major emphasis on this subject.

These federal experiences provide a sound basis for a thoughtful, reasonable approach to the predictably difficult task of cutting the training programs in certain specialties. A variety of models for the federal system could be developed, ranging from highly centralized to largely decentralized. With substantial private sector involvement, the traditional professional lines of decisionmaking need not be highly disrupted. The prospect of such involvement has grown recently. Unlike their posture for many years, many of the affected specialties, training programs, and academic health centers now seem poised to cooperate with appropriate federal measures. First, the number of practitioners needed in each field can best be forecast on a national basis. Then, the flow of training funds can be directed to assure that they go toward meeting this goal. All of this can be done in a way that assures that the integrity and quality of specialty training is preserved, and that opportunities are not unfairly restricted. Whatever system for implementing residency controls is put into place, the legislative tool to accomplish this task is simple: redirect training monies. Unlike the open-ended approach that has characterized Medicare GME payments, future payments for specialty training should only be made to programs whose physician training furthers the national policy. Public funds should no longer be used to subsidize the production of unwanted numbers of specialists who will continue to drive up health care expenditures and frustrate reform efforts.

In addition, the benefits of being included in health plans under the new system should only be available to training sites that participate in the national program. Without this lever, training programs will simply use the public support for approved residencies, and will keep unapproved ones going with patient care revenues. The rationale for cutting off self-funded programs is that precisely those specialties that are lucrative enough to generate sufficient patient care revenues to support residency programs are the specialties that are to be reduced in the future. Continuing to pay for operating certain residencies but permitting additional residencies to

operate at their own expense would not control specialty size. Just as Medicare GME payments helped subsidize a vast expansion of specialties and subspecialties, even vastly expanded federal payments would not assure a redistribution without adequate measures to prevent the development of "rogue" programs. Without a strong provision, many highly remunerative programs would be developed and so subvert the policy that 55% of new physicians should be trained in primary care. Since virtually all of the patient care dollars that would be used will be either public funds or funds being spent under the federal mandate, programs should use those funds to further the national purpose and not to continue specialty expansion.

Fifth, health care reform presents a unique opportunity to reduce the need for many people in the inner-city to go to large teaching hospitals and clinics for their medical care, and to redirect specialty training at the same time. Universal coverage will provide new opportunities for everyone to receive mainstream medical care, and new challenges to teaching programs to broaden clinical teaching beyond the traditional population of low-income individuals. Mr. Chairman, I believe it is critically important to separate the service function from the teaching mission in medical education. In many cases, teaching hospitals are located in areas where few practitioners provide service. Because residency training necessarily involves doing-while-learning, many people have become dependent on the services provided by residents and fellows. But I believe that we should recognize that relying on training programs to deliver services in health professional shortage areas is at best a stopgap measure for desperate situations.

One major implication of sustaining unnecessary hospital-based, high-technology, residency and fellowship programs simply because they provide needed services is that excess numbers of specialists get trained in the process, and move on to practice in other communities. Training programs are, in a real sense, production lines, not service delivery entities. Medical schools produce physicians, residency programs produce specialists and subspecialists. While residents may represent a source of cheap and highly profitable labor while in training, reliance on training programs for service ultimately is extremely costly and inefficient in the long run when trainees become specialist practitioners.

Another serious implication of sustaining training programs for their ancillary service function is the character and quality of the care provided. Mr. Chairman, even the smartest and most dedicated medical students and residents are not as skilled when they are in training as they are when they finish and go into practice. By definition, they are not as experienced as they will be during their careers. And, because they are in training, they turn over on a regular basis. People who have no choice but to rely on training programs for medical care are assured neither seasoned, competent practitioners nor continuity of care.

For many years, however, the dilemma has been that the sudden withdrawal of services delivered by training programs would be highly disruptive unless other arrangements were made to assure access to practitioners and facilities. That is precisely why the logic is so strong for redirecting our training programs in the context of national health care reform. Universal coverage for comprehensive benefits will permit many individuals to receive private care for a sustained period for the first time. With fully universal, comprehensive coverage, there should be little financial reason for discriminating between teaching patients and private patients.

Nevertheless, it is clear that some measures will be necessary to assure access even to insured individuals in many low-income and traditionally underserved areas, since practitioners may not move in overnight to set up private offices there. The solution, however, is not to sustain training programs, but to expand service delivery programs. Health plans should be required to provide services throughout local areas. Community health centers, public hospitals and clinics, and National Health Service Corps sites should be sustained and expanded as necessary. There should be no question of reducing jobs, only of emphasizing jobs in the delivery of health care rather than training of health professionals. Individuals should be admitted to teaching hospitals because they need the sophisticated care available in those hospitals, not because unneeded trainees require clinical experiences to become certified.

In the short run, of course, there will be problems in the transition period. Some hospitals that have relied on certain lucrative clinical services staffed by residents will have to develop alternative staffing patterns, or close down those services. Faculty unaccustomed to active clinical practice may have to see patients and take night call themselves, or be replaced by health professionals who do so. Financial and organizational assistance to achieve these changes should be provided as part of the health reform package.

Mr. Chairman, for all the wonderful efforts that so many teaching physicians and trainees have made over the years to care for people in their clinics and hospitals,

I feel strongly that health reform should offer mainstream care to everyone. Teaching programs should be sustained for teaching purposes, not to deliver services.

Sixth, and last, health care reform itself could well be jeopardized by failing to reform the workforce. Continued growth in the number of inappropriately trained specialists will create an ever-larger cadre of health professionals who would feel threatened by and work to defeat comprehensive health care reform. One further consequence of failing to bring the production of specialists into line with overall federal policy is that the continued production of more and more practitioners in the high-technology procedural specialties will make it all the more difficult to control spending and achieve universal coverage. We physicians have proved quite enterprising in finding ways to be paid to put our training into practice, whether needed or not. The more surgeons, the more surgery; the more gastroenterologists, the more fiberoptic tubes that find their way into gastrointestinal tracts.

A substantial excess of specialty care in active practice inappropriately defines what care is needed. If the standard in the fee-for-service sector is excessive care, it is all the more difficult for HMOs and other managed care systems to set more rational standards. Similarly, it is more difficult to develop and expect physicians to follow more rational medical practice guidelines if the standard of practice reflects the supply of physicians and technology more than the needs of patients. Allowing the surfeit of highly specialized physicians to continue to grow will sustain pressures against a system of care based on sound scientific knowledge and reasonable medical decisionmaking.

In the absence of sound national policy to the contrary, if we continue to produce hundreds of thousands of highly trained physicians we should not expect them readily to suffer the prospects of limited opportunities. Even as their numbers have skyrocketed in recent years, highly specialized physicians have been able to achieve a remarkable and sustained growth in their incomes relative to those of primary care physicians. (Figure 6) Having survived more than seven years of advanced training, specialized physicians quite reasonably are likely to resist the expansion of managed care plans and cost-containment measures that they perceive as likely to curtail further growth in their earnings. Federal funds have too long been used to create this well-heeled constituency with strong interests against reform. Continued expansion of their numbers will only exacerbate both their motivation and their numbers.

GRADUATE MEDICAL EDUCATION TRAINING PROVISIONS IN HEALTH REFORM PROPOSALS
(figure 7)

1. Administration Plan: S. 1757: Mitchell

Each of the priority areas that I have identified is addressed in the Health Security Act. A national goal is established to have 55% of residency graduates enter practice in primary care, and numerous mechanisms to attain that goal are created. Existing federal policies are revised: Medicare funds for graduate medical education are pooled with those from other public and private sources, and are spent only on residents who come under the national program. Permanent, mandatory sources of all funds are provided. The Secretary of the Department of Health and Human Services and a National Council on Graduate Medical Education are charged with setting limits on the number of graduates from specialty training programs, with extensive private sector involvement. There is some enhancement of primary care research, along with the authorization of additional funds to support biomedical and behavioral research in the area of health promotion and disease prevention. And, although I have not mentioned the important facet of teamwork in primary care previously, substantial funds are provided for training of a wide range of primary care practitioners, including advanced practice nurses.

2. S. 491: Wellstone

Mandatory targets are established, to reach a 50–50 distribution of residents in primary care within five years. An Advisory Committee to the National Board on Health Professions Education is established. The Board would enforce the target by cutting payments to State health security programs if goals are not met.

3. S. 1770: Chafee

Establishes up to seven demonstration projects to permit states to increase primary care by pooling direct GME payments to test ways to change specialty mix.

4. S. 1579: Breaux

Places limits on the number of specialty residents. Health Care Standards Commission would determine the number and funding level of residency positions. Eliminates current GME funding and establishes a national medical education fund,

with payments into the fund from Medicare and health plans. Provides for retraining in primary care for physicians in other specialties.

CONCLUSION

Time and again, the Congress has recognized the importance of federal direction and support in the training of health professionals. The federal primary care grant programs, the incentives built into the RB/RVS system of paying physicians under Part B of Medicare, the modest adjustment of Medicare GME payments in the direction of primary care, and the long history of support for the construction and expansion of medical schools and teaching hospitals are all testimony to Congress's commitment to ensuring that the health professionals of this country serve the nation's needs. Now, as you address the pressing need to enact comprehensive health care coverage for all, you have the opportunity to assure that the system of training health professionals helps and does not hinder accomplishing comprehensive health reform.

Mr. Chairman, I believe that it is time to direct public funds and efforts to assuring a mix of practitioners that will serve the needs of the public and to stop subsidizing the wasteful expansion of specialty training. I thank you for your attention, and I would be delighted to answer any questions.

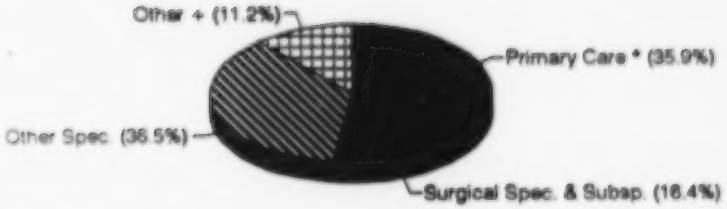
ENDNOTES

1. Budetti P. Achieving a Uniform Federal Primary Care Policy. Opportunities Presented by National Health Reform. JAMA 1993;269:498–501.

2. American College of Physicians. Universal insurance for American health care. Ann Intern Med 1992;117:511–519.

APPENDIX

Physician Supply
By Specialty, 1990



* Includes Family Practice, General Practice, General Internal Medicine, General Pediatrics, and OB/GYN.

+ Other includes Not Classified, Inactive, and Address Unknown.

Source: Physician Characteristics & Distribution in the US, 1993 and previous editions, AMA
American Osteopathic Association, FY-90 Data, Biographical Records, 1993.

Figure 1

From "A Chartbook on the Supply, Training, and Distribution of Physicians"
M. Salloway, K. Weiss, M.J. Pagan
January 1994

Center for Health Policy Research
The George Washington University

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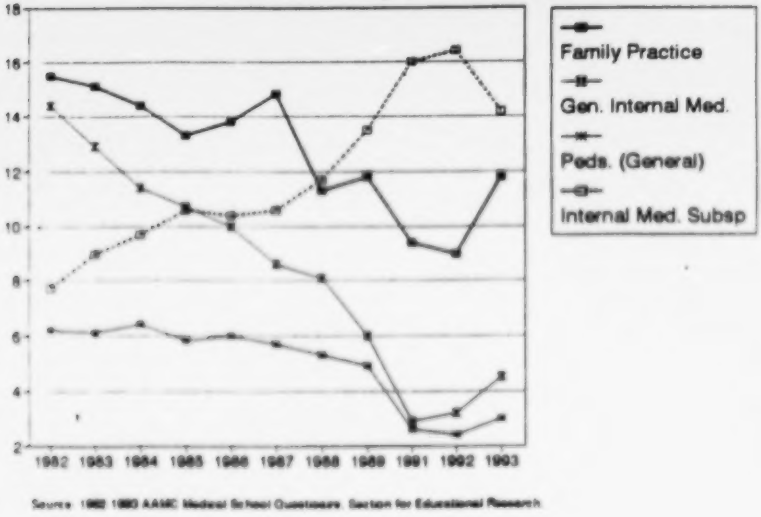
Specialty Certification Plans
Of Graduating Medical Students



Source: 1982-1990 AAMC Medical School Questionaire, Section for Educational Research

Figure 2

Chart prepared by P. Budetti & M. Fagan

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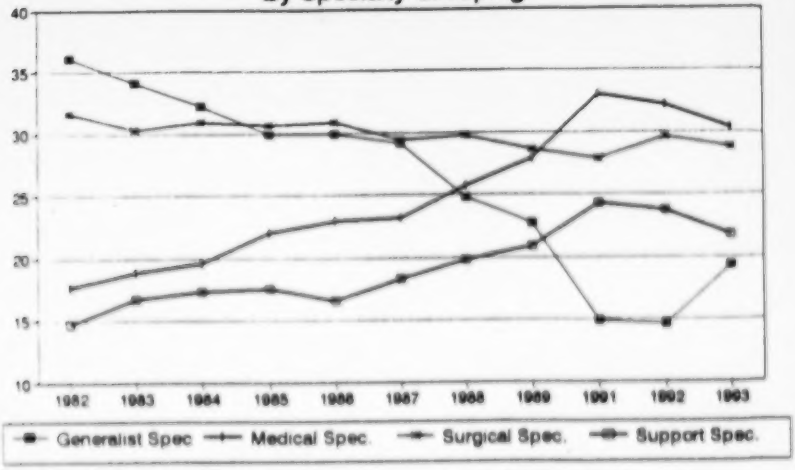
Specialty Certification Plans
Of Graduating Medical Students
By Specialty Grouping



Source: 1982-1993 AAMC Medical School Graduation Questionnaire, Section for Educational Research

Figure 3

Chart prepared by P. Budetti & M. Fagan

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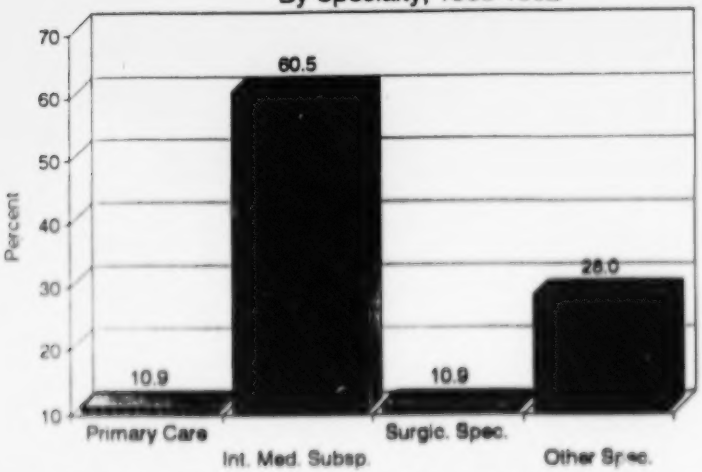
Growth in Residency Positions

By Specialty, 1988-1992



Source: AAMC, GME Counts by Program Year, 1993. AOA, Biographical Records, 1993, With analysis by David Kindig, MD, PhD, and Donald Libby, PhD, University of Wisconsin, School of Medicine, Health Policy Program.

Figure 4

From "A Chartbook on the Supply, Training, and Distribution of Physicians"
M. Sullivan, E. Weiss, M.J. Fagan
January 1994

Center for Health Policy Research
The George Washington University

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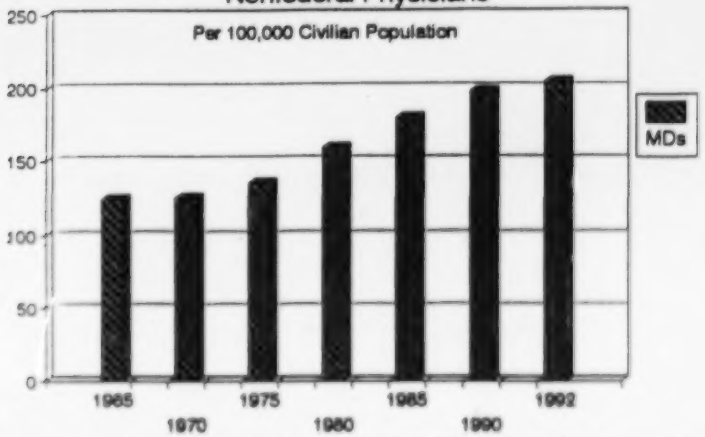
Patient Care Physicians*

Nonfederal Physicians



Notes: * Includes office-based physicians, hospital-based physicians, and residents. Data for 1990 and 1992 include a new category of clinical fellows, which account for respectively 6,691 and 7,128 physicians.

Sources:
US Bureau of the Census, "Current Population Reports", Series P-23, Nos. 1075 & 1043, US GPO, Washington, DC, March 1980 & 1992.
Health Manpower Source Book, US Dept. of Health, Education, & Welfare, Public Health Service, Publication No. 283, Sec.20, US GPO, 1966
Physician Characteristics & Distribution in the US, 1980 & previous editions, AMA.

Figure 5

From "A Chartbook on the Supply, Training, and Distribution of Physicians"
M. Sullivan, K. Weiss, M.J. Fagan
January 1994

Center for Health Policy Research
The George Washington University

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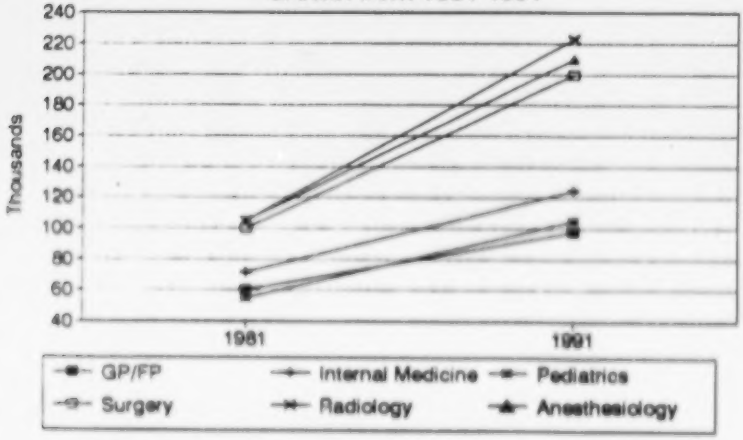
Median Physician Net Income

After Expenses, Before Taxes

Growth from 1981-1991



Note: The incomes represented are in nominal dollars.
Source: Socioeconomic Chracteristics of Medical Practice, 1993, AMA

Figure 6

From "A Chartbook on the Supply, Training, and Distribution of Physicians"
M. Sullivan, E. Weiss, M.J. Pagan
January 1994

Center for Health Policy Research
The George Washington University

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SUMMARY OF
REFORMS IN HEALTH PROFESSIONS EDUCATION

CURRENT SITUATION	American Health Security Act HR 13995/S 491 McDermott/Wellstone	Health Security Act HR 3600/S1757 President Clinton/ Gephardt/Mitchell	Health Equity and Access Reform Today Act of 1993 HR 3704/ S 1770 Thomas/Chafee	Managed Competition Act of 1993 HR 3333/S 1579 Cooper/Breaux
• 50% GME paid for by Medicare, which favors tertiary care and specialization • Only 14% of current medical students are choosing primary care (1992) - less than half the rate (36%) in 1982	• Mandatory reforms • Establishes target of 1:1 primary care providers to specialists five years after enactment of legislation • Establishes Advisory Committee on Health Professional Education • Reduces payments to States that fail to meet national goals for graduate medical education • Health Board will establish target number of medicaid primary care practitioners by year 2000 • Increases funding to support health professions education and nursing education, including nurse practitioners, certified registered nurse anesthetists, certified nurse midwives, and physician assistants • Increases funding for NHSC	• Mandatory reforms • Provides new entitlement grant funding academic health centers for medical education • Replaces GME and IME payments for Medicare • GME payments to emphasize primary care training • Limits the number of specialty residencies • Increases the authorization for funding for training of nurse practitioners and physician assistants • Establishes National Council of GME within DHHS • Authorizes expansion of NHSC • Overrides restrictive State practice laws but health plans can still decide which providers it allows to participate in their networks	• Voluntary reforms • Creates GME demonstration projects which allows States to pool GME funds and change specialty mix • Provides tax incentives for primary care providers in underserved areas • Increases the authorization for primary care physicians • Increases the authorization for funding for training of nurse practitioners and physician assistants • Increases the authorization for funding for PHS and NHSC • Provides tax breaks for NHSC loans	• Mandatory reforms • Establishes National Medical Education Fund • Eliminates separate medical education payments under Medicare • Limits the number of specialty residencies to 110% of applicants • Differential funding for primary care; 25% higher than specialty slots • Increases the authorization for funding for training of mid-level practitioners, NHSC, and Area Health Education Centers • Overrides restrictive State practice laws but health plans can still decide which providers it allows to participate in their networks

Kaiser Commission on the Future of Medicaid

Figure 7

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RESPONSES OF DR. BUDETTI TO QUESTIONS SUBMITTED BY SENATOR DOLE

Question No. 1. In your testimony you suggest that the current method of financing manpower training has led to an over supply of specialists.

If the problem is money, why not simply change the financing and let the market work? Why do we have to force allocation of residencies by placing absolute Federal limits on the number and type of residencies?

Answer. In my opinion, the current method of financing of graduate medical education (GME) has been a major factor in creating an over supply of specialists in fields other than primary care. agree that it would seem natural to seek a solution by simply changing the financing. To date, however, the only approaches to changing the financing that seem likely to have the desired effect require limits on the number and type of residencies. For example, one might set a policy that GME funds would be provided only to primary care residencies, however many there are, and other programs would be on their own. In that case, the likely result would be that the other specialties would continue to expand. It is precisely those specialties that are lucrative enough to generate sufficient patient care revenues to support residency programs that are the specialties that are to be reduced in the future. If one were to pay for operating primary care residencies but additional residencies could operate at their own expense, there would be no effective control on specialty size. Without controls on their numbers many highly remunerative programs would be developed to serve the short-term financial interests of the teaching hospitals and thereby subvert the policy that 55% of new physicians should be trained in primary care.

In addition, to the extent that the market can help redirect specialty training, there would be an enormous time lag. In the meantime, so many additional specialists would be trained—largely at public expense—that the realignment would be even more difficult. In short, federal action to limit growth in nonprimary care specialties is needed to assure that we have an appropriate health care workforce in the future.

Question No. 2. Once you cap the absolute number of residencies and the distribution—what makes you think physicians will choose to locate where you believe they belong? Nothing we've done so far has achieved the kind of geographic distribution we need.

Answer. I agree that specialty and geographic distributions are quite different. Each needs its own policy support. In large part, universal coverage is one approach to moderating inequities in the location of physicians by permitting choices to be made without regard to the financial status of individuals in the area. Nevertheless, even with universal coverage, many rural and inner-city areas will lack adequate health professionals. Programs such as the National Health Service Corps, Community and Migrant Health Centers, and essential community providers are likely to be necessary to assure adequate access for some time in the future.

Question No. 3. You have made no recommendations as to the training or use of non-physician providers. In the rural states like Kansas, nurse practitioners, optometrists and others are vital. What can we do to increase their numbers and their use?

Answer. As I noted, my testimony focused on physicians, but I strongly support enhancing the training of nurse practitioners and other health professionals by redirecting and adding to funds now available for that purpose. Not only are they important in many rural states and other areas, they also enhance opportunities for the delivery of comprehensive services. Nurse practitioners are a valuable component of a team-approach to primary care. Physician assistants as well as nurse practitioners can also be trained in specialties other than primary care to help alleviate the need to have residents simply for the purpose of service delivery.

Question No. 4. When you place a cap on the total numbers of residencies how do you envision that we would distribute these numbers? There are a limited number of states that produce the largest numbers of residencies. For example, I understand that New York state alone trains 15 percent of all residents. (12 percent in New York City alone—60 percent more than the next largest state, California.)

I, for one, don't want to tell the Chairman that Kansas is going to gain residents at the expense of New York.

New York also has a very large number of international medical graduates. How do you propose we choose between U.S. and foreign students?

Answer. There are a variety of ways that the residency slots could be distributed. The total number of residents in each specialty should be determined on the basis of the best estimates of future national needs. Then, these could be allocated on a national, regional, or state basis. Clearly, any allocation system should take into account the fact that certain areas of the country have developed the capacity to oper-

ate large numbers of excellent training programs. It would be wasteful and create a great deal of hardship simply to redistribute programs on a formula that fails to recognize these differences.

Nevertheless, it is also important to separate the service function from the teaching mission in medical education. To the extent that training programs are sustained not for their excellence but because many people are dependent on the services provided by residents in teaching hospitals in areas where few practitioners provide service, the problem is one of access to care that needs to be addressed directly. Reliance on training programs for service is extremely costly and inefficient in the long run when trainees become specialist practitioners, and does not assure people a continuing source of high-quality care.

As efforts to expand services proceed, it will be necessary to sustain existing delivery systems such as large urban teaching hospitals for so long as they are essential in their communities. The sudden withdrawal of services delivered by training programs would be highly disruptive unless other arrangements were made to assure access to practitioners and facilities. That is why changes in training programs need to be done in the context of national health care reform. Health care reform presents a unique opportunity to reduce the need for many people in the inner-city to go to large teaching hospitals and clinics for their medical care, and to redirect specialty training at the same time. Universal coverage will provide new opportunities for everyone to receive mainstream medical care. In the short run, however, there will be problems in the transition period. Financial and organizational assistance to achieve these changes should be provided as part of the health reform package.

I do not propose that we choose between U.S. and foreign students. Choices among applicants to residency programs should be made by the programs themselves.

Question No. 5. Given the amount of time necessary to train a physician (3–8 years of residency following medical school), what happens if we guess wrong and produce the wrong distribution? Demographics being what they are—I can't imagine we won't need happens if we guess wrong and produce the wrong distribution? Demographics being what they are—I can't imagine we won't need urologist, cardiologists, and other specialties.

Answer. Precisely because of the long lag time from training to practice and the uncertainty of any human predictions, all such decisions should be based on the best available evidence and in a way that is flexible enough to adapt to changing circumstances. At the present time, we are skewing the future supply of specialists on a far less rational basis. We currently provide substantial federal funds to teaching hospitals without regard to societal needs. Specialty training programs can receive subsidies to expand for whatever reason they choose, and tend to do so in the areas that serve the immediate needs of the institutions. The remarkable expansion of specialty residency slots by 60 percent in the four years between 1988 and 1992 can hardly be explained by parallel changes in future practice needs.

Question No. 6. We will hear from Dr. Colwill that decision making has to be *local*—you suggest that it should be *national*.

Answer. Please see my answer to number 4, above.

RESPONSES OF DR. BUDETTI TO QUESTIONS SUBMITTED BY SENATOR GRASSLEY

Question No. 1. You noted on page three of your statement that one of the Federal incentives that helps to produce an excessive number of specialists is ". . . support for a vast expansion of biomedical research in academic health centers and teaching hospitals."

This raises a number of interesting questions.

Does your point imply that we should be cutting back on such investments in research? And, if we do, aren't we going to deprive our citizens of the benefits of that research?

And, if we want the benefits of that research, don't we have to train the specialists who can use it in providing care?

Answer. The quantity and quality of biomedical research in the United States is one of the jewels in the crown of American medicine. Our national commitment to such research should not be reduced. It is the very magnitude of our investment in biomedical research that highlights the paucity of our spending for primary care research. What is needed is a substantial commitment to primary care research both to advance knowledge and to attract young physicians into that field.

Primary care research addresses the knowledge base supporting primary care practice, the biobehavioral environment of primary care, and the organization and financing of primary care services.[1] It strives to focus on the individual disease or organ system, and to emphasize prevention,[2] not a Opposition from proponents of

biomedical research and a lack of perceived value have made it difficult to establish an adequate research base for primary care.

For its own part, with little federal financial support, primary care research has been slow to develop. Only since the establishment of the Agency for Health Care Policy and Research (AHCPR)[3] has there been a federal entity dedicated to primary care research, the Division of Primary Care within AHCPR. This is far less than a full-fledged Institute for Primary Care,[4] but the field has not had the necessary recognition or constituency for an Institute to date.

The relative order of magnitude of federal research support makes it clear that developing a substantial primary care research base will be difficult. For FY93, NIH has funding of $10.4 billion, while AHCPR has total funding of about $129 million. One recent estimate was that probably no more than $40 million in federal funding is available for primary care research from all sources. Ironically, the NIH was the source of about one-half that amount, even though spending on primary care at that rate would represent only 0.002 of the NIH budget.[5]

Primary care research also has had an image problem that exacerbates the difficulties of attracting students into the field. Some $4 billion in biomedical research support goes to medical schools, accounting for about 20% of medical school budgets.[6] Unable to attract funds on that order of magnitude, primary care researchers are far less numerous or visible to medical students and rarely found in prestigious positions within medical schools. Moreover, because primary care research is seen as dealing with mundane, everyday health care concerns rather than high-tech or life-and-death diseases, it has long been undervalued by policymakers.[7]

Medical students identify with faculty whom they perceive to have the highest status. With infrequent exposure to well-established primary care researchers in prominent positions, students have the notion that only specialists in other fields can do important research. This is a barrier to many students appreciating the value of a career in primary care.

To benefit from any research, of course, we need to train specialists who can use the findings of that research. Subsidizing the training of unlimited numbers of specialists is a crude and inefficient way to reach that goal—and, in itself, is no guarantee of success. First, well-trained primary care practitioners are fully qualified to practice quite sophisticated medicine. For care that is beyond the ability or expertise of primary care specialists, what is needed is the appropriate number of specialists in other fields.

The best way to assure that public funds are generally going toward production of the most appropriate mix of specialists is to make decisions based on the best available evidence and in a way that is flexible enough to adapt to changing circumstances. At the present time, we are skewing the future supply of specialists on a far less rational basis. We currently provide substantial federal funds to teaching hospitals without regard to societal needs. Specialty training programs can receive subsidies to expand for whatever reason they choose, and tend to do so in the areas that serve the immediate needs of the institutions. The remarkable expansion of specialty residency slots by 60 percent in the four years between 1988 and 1992 can hardly be explained by parallel changes in future practice needs—let alone by the need to incorporate scientific breakthroughs into medical practice.

Question No. 2. As you know, may of our rural and frontier areas, as well as many of our inner city areas, have experienced problems over the years in recruiting and retaining health care providers.

May I have your views on how we should address this? It is hard for me to believe that just producing more primary care providers would have that result.

Answer. I agree that simply changing the specialty mix to favor primary care will not completely solve problems with geographic distribution. Doing so will certainly help, however, since primary care practitioners are more willing to work in sparsely populated areas and are not dependent on having sophisticated hospitals nearby. In large part, universal coverage is one approach to moderating inequities in the location of physicians by permitting their choices to be made without regard to the financial status of individuals in the area. Nevertheless, even with universal coverage, many rural and inner-city areas will lack adequate health professionals. Programs such as the National Health Service Corps, Community and Migrant Health Centers, and essential community providers are likely to be necessary to assure adequate access for some time in the future, and health reform should address this need.

In addition, strong support for enhancing the training of nurse practitioners and other health professionals by redirecting and adding to funds now available for that purpose will also help address geographic disparities. These practitioners are very important in many rural states and other areas. In addition, they enhance opportunities for the delivery of comprehensive services through linkages into a team-ap-

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proach to primary care. Physician assistants as well as nurse practitioners can also be trained in specialties other than primary care to help alleviate the need to have residents simply for the purpose of service delivery purpose.

ENDNOTES

1. Hibbard H, Nutting PA. Research in primary care: a national priority. in *Primary Care Research: Theory and Methods.* Rockville, MD: Agency for Health Care Policy and Research (Publication No. 91–0011); 1991.

2. Estes EH. Primary care research: Where have we been? Where are we going? in *Primary Care Research: An Agenda for the 90s.* Rockville, MD: Agency for Health Care Policy and Research, DHHS Publication No. (PHS) 90–3460, 1990.

3. Title IX, Public Health Service Act (42 U.S. C. 299) and section 1142, Social Security Act (42 U.S.C. 1301 et seq.)

4. Graham R. The professional organization's perspective of primary care research. in *Primary Care Research: An Agenda for the 90s.* AHCPR Conference Proceedings. Rockville, MD: Agency for Health Care Policy and Research, DHHS publication no. (PHS) 90–3460, 1990.

5. Mullan F. The federal government in primary care research. in *Primary Care Research: An Agenda for the 90s.* Rockville, MD: Agency for Health Care Policy and Research, DHHS Publication No. (PHS) 90–3460, 1990.

6. Jolin LD, Jolly P, Krakauer JY, Beran R. U.S. medical school finances. JAMA 1991;266:985–90.

7. Budetti P. The legislative perspective on primary care research. in *Primary Care Research: An Agenda for the 90s.* Rockville, MD: Agency for Health Care Policy and Research, DHHS Publication No. (PHS) 90–3460, 1990.

PREPARED STATEMENT OF JACK COLWILL

Senator Moynihan, Senator Packwood, and Members of the Senate Committee on Finance:

I am Jack Colwill, M.D., Professor and Chairman of the Department of Family and Community Medicine at the University of Missouri-Columbia School of Medicine. I am a member of the Executive Committee of the Congressionally authorized Council on Graduate Medical Education (COGME) and I speak on behalf of the Council.

Fundamental problems exist in the composition of this nation's physician workforce. We have too many specialists and too few generalists. We face an increasing surplus of physicians (Figure 1) while the number of minority physicians and physicians serving in rural and inner city locations continues to be totally inadequate. The percentage of generalists—those in family practice, general internal medicine, and general pediatrics—has been declining throughout the past 40 years. (Figure 2) Today only a quarter of allopathic medical school graduates are entering generalist practice. (Figure 3) At the same time, inadequate numbers of generalists will impede the development of managed systems of care and will limit our ability to address physician workforce needs of rural and inner city settings.

Today, our physician supply is more than adequate. Tomorrow, we shall face an increasing surplus. The physician to population ratio will increase by almost 25% between now and 2020. Twenty-four thousand physicians are now entering graduate medical education anually—35% greater than the total of U.S. allopathic and osteopathic medical school graduates. The total number of residents in graduate medical education has increased 19% between 1988 and 1992 as increasing numbers subspecialize. An increasing surplus of physicians will stimulate excessive utilization of services in the fee-for-service sector. Increasing underemployment of physicians will occur as managed care, with its reduced physician requirements, serves higher proportions of the U.S. population. My comments today focus upon those components of COGME's Fourth Report which deal with graduate medical education (GME).

Medicare currently pays teaching hospitals approximately six billion dollars annually for the direct and indirect costs associated with graduate medical education. There is no limit on the numbers of positions funded and no stipulation on the specialty mix of positions funded.

COGME believes that Medicare funds utilized to support graduate medical education should be utilized to train the number and specialty mix of physicians which are needed by this nation. The Fourth Report of COGME recommends fundamental restructuring of the funding of GME. Its goals are to reduce the number of positions funded to the number of U.S. medical graduates plus ten percent and to achieve a 50% mix of generalists and specialists. These overall goals have been endorsed by

many other groups as well as the Clinton health plan. COGME recommends that we accomplish these goals in a predictable and timely fashion decentralizing decision making to the local and private level under broad national workforce mandates.

COGME believes that market forces created by a changing health care system will not correct these workforce deficiencies in the near future. The financial rewards for specialists in the marketplace, the specializing influence of medical education, and the dependence of teaching hospitals on residents to provide service have been powerful forces which have tended to maintain the status quo.

COGME's Fourth Report makes legislative recommendations which:

- assure that 50% of graduates become generalists;
- limit total funded positions to the number of U.S. medical school graduates in 1993 plus ten percent;
- allocate the reduced number of GME positions to medical school coordinated consortia;
- provide funding for graduate medical education by *all* third party payers;
- provide transition payments to those hospitals most affected by the loss of resident positions;
- expand incentives for individuals and institutions to graduate more generalist and minority physicians, to improve the geographic distribution of physicians, and to build the primary care teaching capacity necessary for an expanded training of generalists by increasing funding of Title VII and the National Health Service Corps;
- establish a National Workforce Commission to oversee allocation of residency positions and to advise Congress and the Department of Health and Human Services (DHHS) on issues of physician workforce policy.

The centerpiece of COGME's proposal is the development of private sector consortia which would function as accountable partnerships in the allocation of residency positions. These consortia would be composed of one or more medical schools, teaching hospitals, other institutions, and representatives of the public. The Department of Health and Human Services would allocate an overall reduced number of residency positions to each consortium utilizing criteria developed by the National Physician Workforce Commission. Each consortium, coordinated by one or more medical schools, would be expected to increase generalist physicians and to reduce specialty positions so that half of all trainees would become generalists. Funding of the consortium would be conditioned upon achieving the above expectation. Decisions on allocation of residency positions within each consortium would be made collectively by the consortium based upon local, state, and regional health care needs as well as the quality of individual programs within the consortium. Funding for the trainee and associated educational costs would follow the trainee to sites of education. This consortium proposal does not attempt to define at the national level the exact number of residency positions that should be offered in each of the 81 specialties at each institution. COGME believes that this task would be extraordinarily difficult and would provide excessive micromanagement of the system. It recommends that these decisions be made at the local level.

A National Workforce Commission should monitor trends in workforce production and needs. It should recommend to Congress and the Secretary of DHHS ongoing modifications in workforce goals, provide guidelines for allocations of overall positions to each consortium, and provide recommendations for addressing shortages and surpluses in specific specialties. In order to carry out its mission, this National Workforce Commission must be adequately funded and staffed.

COGME believes strongly that all third party payers should contribute to the costs of graduate medical education. Medicare currently pays its pro rata share of the cost of graduate medical education. The remainder of the direct costs are derived primarily from other sources of patient care income. As teaching hospitals increasingly compete with community hospitals on the basis of price, they will find it progressively difficult to fund graduate medical education—especially the high costs related to the education of generalists.

Society will be benefited by implementation of COGME's proposals. However, a reduction in residency positions is not easily accomplished. Institutions express concerns about methods of allocating reduced numbers of positions, means of providing services currently provided by residents, the potential loss of GME income, the requirement that 50% generalists be graduated, and the governance and function of consortia.

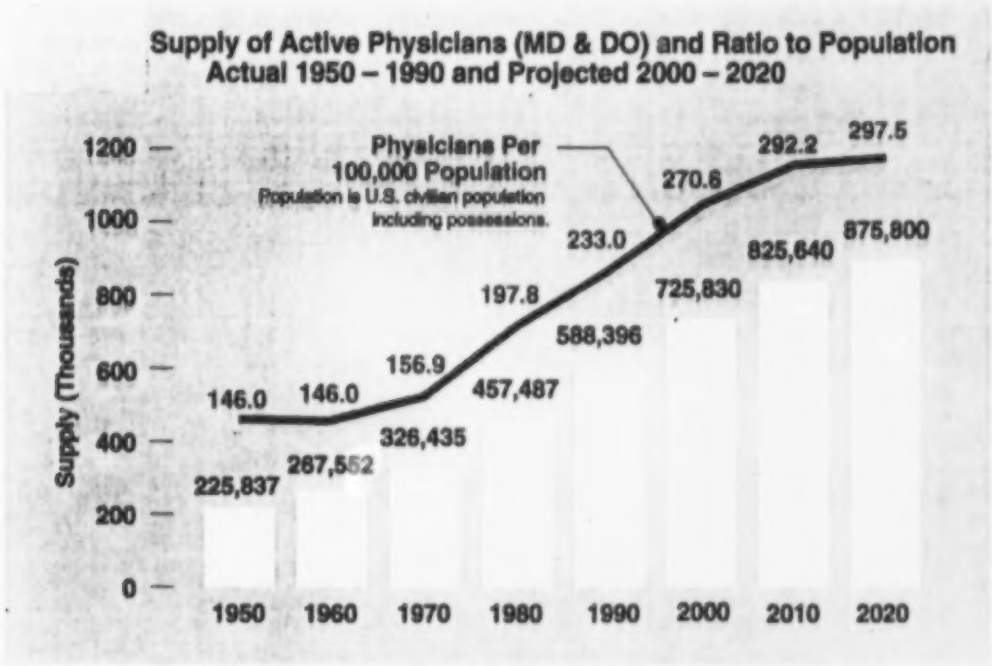
COGME is continuing to refine its recommendations about these issues. It recognizes that most residency programs already are affiliated with medical schools. Consortia already are developing in many areas. Under COGME proposals, decisions about allocation of residency positions should be made collectively by the member-

ship of the consortium. The membership of each consortium is not locked in stone. Individual member institutions may find it advantageous to move to other consortia. Loss of GME funds poses a significant problem. Financial considerations need to be separated from needed GME changes. Thus, the current stream of funds to institutions most affected might be maintained to make it easier for them to employ other providers to meet service needs. Assignment of National Health Service Corps personnel to settings such as New York City might also be of assistance. The recommended changes should be implemented over several years to reduce the immediate impact upon individual institutions. Some states may wish to develop demonstration projects for allocation of residency positions under overall federal guidelines as included in the Fourth Report. Additional options for governance and allocation of funds within the consortia are being explored.

If Congress enacts COGME's recommendations, our educational institutions would increase the proportion of generalists educated to 50%. The physician growth rate would more closely parallel that of the population. (Figure 4) An increased production of family physicians would increase the number of rural physicians. The increased numbers of generalists would provide the needed generalist physician infrastructure for expansion of managed systems of care. Fewer specialist physicians would be underemployed and the tendency to provide unnecessary services would be reduced. Our nation would provide a physician workforce much more closely matched to tomorrow's health care needs.

I wish to thank the Committee for this opportunity to present the recommendations of the Council on Graduate Medical Education.

FIGURE 1



Source: 1950-90 data from AMA Masterfile adjusted by BHPr to partially include unknown activity status or address. 2000-20 projected data from BHPr Physician Forecasting Model.

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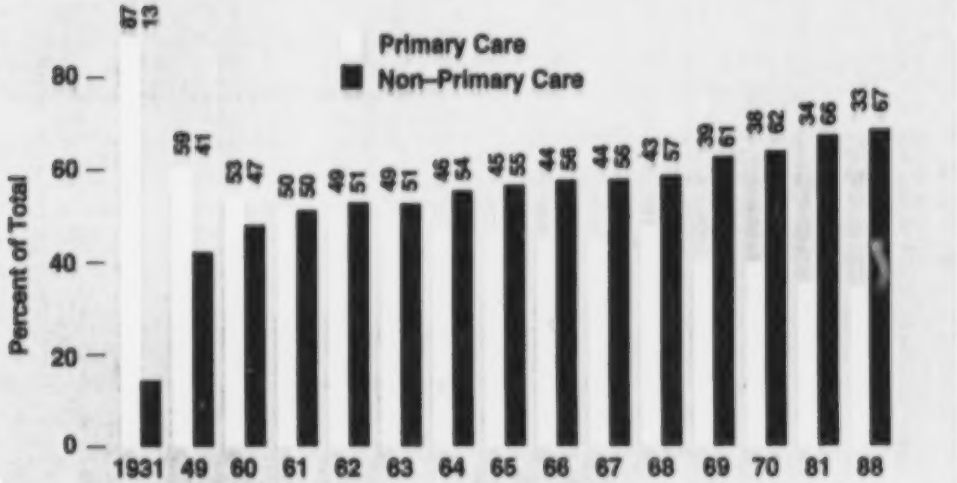
FIGURE 2

A Steady Decrease in Primary Care MDs* Compared to Other Specialties: Selected Years 1931-88



* Family physicians, general internists and general pediatricians
Note: The AMA reclassified MDs in 1968 causing a 3.5% change in primary and non–primary care.

Source: Pre-1965 data from *Health Manpower Sourcebook: Section 14, Medical Specialists*, Division of Public Health Methods, U.S. Public Health Service, DHEW, 1962. 1965-88 data from *Physician Characteristics and Distribution*, annual editions, AMA.

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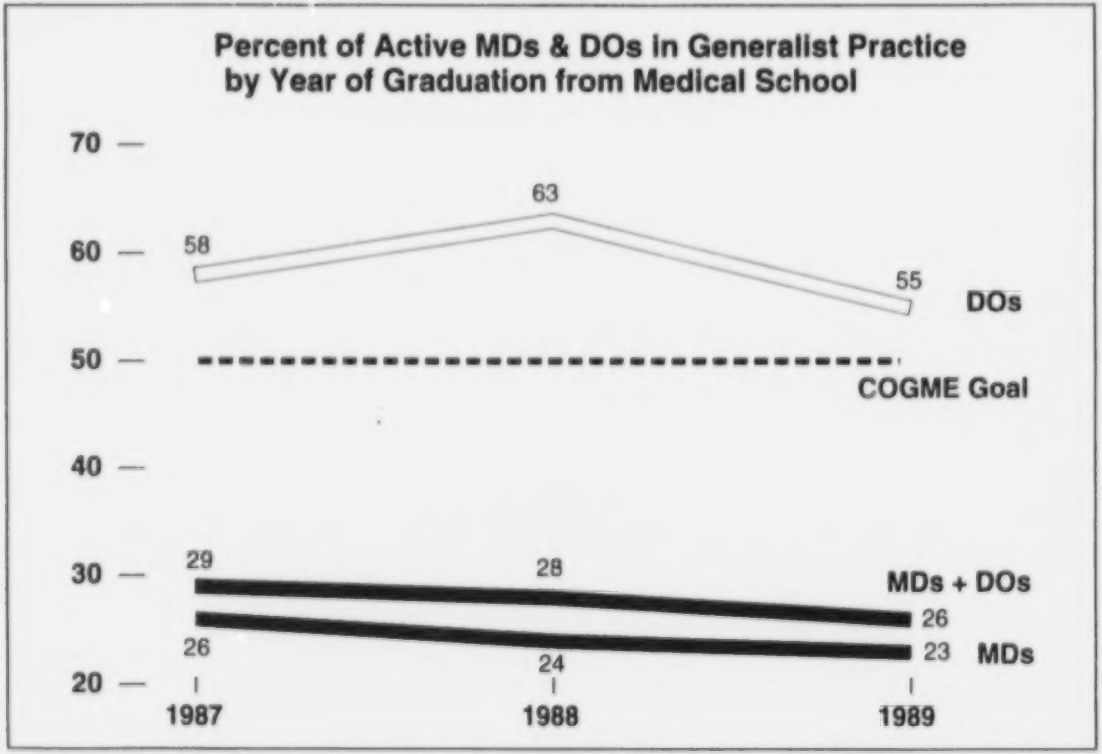
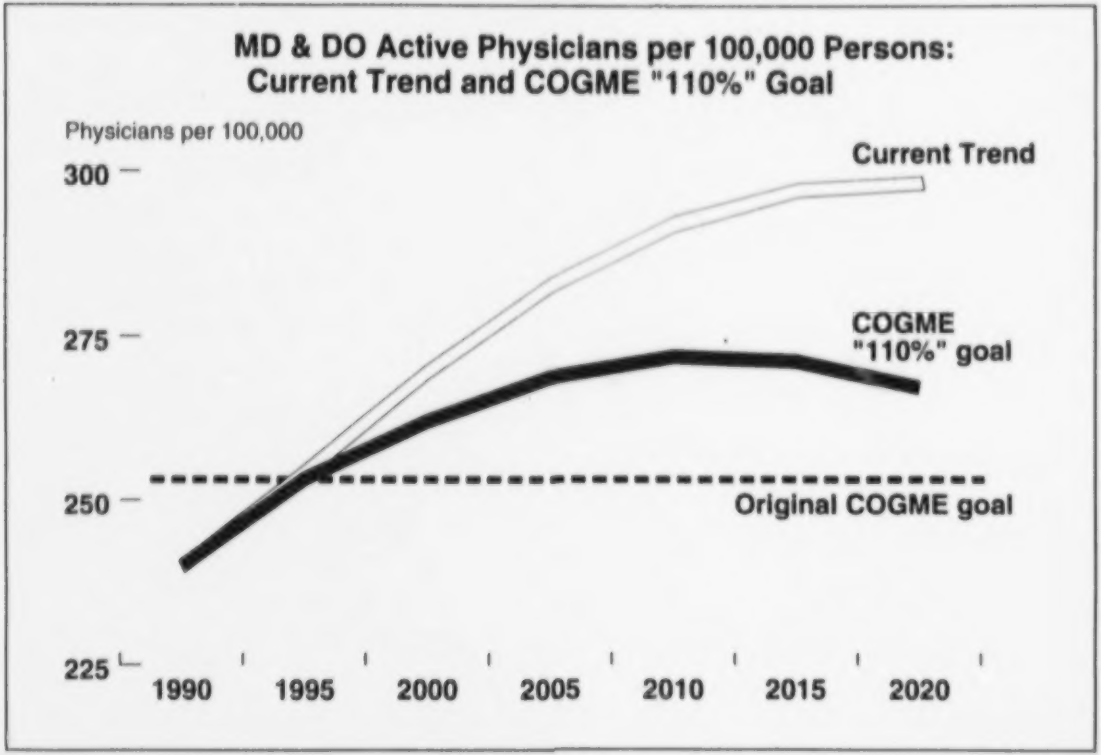
FIGURE 3


Percent of Active MDs & DOs in Generalist Practice
by Year of Graduation from Medical School
70
60
50
40
30
20
63
58
55
DOs
COGME Goal
29
28
MDs + DOs
26
26
24
23
MDs
1987
1988
1989

83-267 O - 95 - 3

FIGURE 4



COUNCIL ON GRADUATE MEDICAL EDUCATION

Fourth Report to Congress and the Department of Health & Human Services Secretary

Recommendations to Improve Access to Health Care Through Physician Workforce Reform

January 1994

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
Public Health Service
Health Resources and Services Administration

EXECUTIVE SUMMARY

Purpose

This Fourth Report of the Council on Graduate Medical Education (COGME) provides policymakers with specific legislative recommendations which, if enacted, would establish a national physician workforce plan and approach to meet the nation's health care needs in the 21st century.

Deficiencies in the Physician Workforce

Recent data reinforces the conclusions of the Council's Third Report that the nation's physician workforce is not well-matched with public needs. Specifically, the nation has too few generalist and minority physicians, too many specialists, and poor geographic distribution of physicians. The mismatch between physician supply and health care requirements will be magnified as the nation establishes universal access to care and the system shifts to systems of managed care. In a managed care dominated health care system, the Bureau of Health Professions projects a year 2000 shortage of 35,000 generalist physicians and a surplus of 115,000 specialist physicians if current patterns of specialty choice and numbers of graduates persist.

Given health care requirements, COGME believes the following physician workforce goals should be attained by the year 2000:

- First year residency positions should be limited to 10% more than the number of US medical school graduates (USMGs plus 10%).
- At least 50% of residency graduates should enter practice as generalist physicians (family physician, general internists and general pediatricians).
- The number of under-represented minority students should be doubled.
- Primary care shortage areas should be eliminated.

If COGME's year 2000 goals were adopted and attained, the nation would produce 25% fewer physicians annually, of whom at least half would practice as generalists. This output is projected to produce a more balanced generalist physician workforce in the year 2020 and a much smaller specialty surplus. Improved minority representation and geographic distribution would significantly enhance care in many underserved communities.

Present trends are not encouraging with respect to meeting the physician workforce goals outlined above. Despite projections of a total physician and specialty surplus, the number of first year residents has continued to grow and the percentage of residency graduates choosing generalist careers has remained low. Although the percentage of minority entrants to medical school has reached a record high, the numbers are well below the desired goal. Continued increases in the ratio of physicians to population has not been associated with a reduction in primary care shortage areas.

In the long run, COGME believes that market forces created by a changing health care system will change the specialty and geographic distribution of the workforce. However, the Council does not believe that these market forces alone will produce the needed physician workforce in a timely or predictable manner. Disincentives in the "educational" marketplace, particularly Medicare graduate medical education (GME) financing policy, blunt the impact of health systems reform on the workforce. Furthermore, the nation lacks a coherent approach to invest public funds in physician training based upon health care analytic requirements. If not corrected, these deficiencies will continue to hinder efforts to expand health care access and to control costs.

COGME'S Legislative Recommendations

The Council's legislative recommendations are designed to:

- utilize public funds which support GME to achieve the number and specialty mix of physicians needed by the nation.
- provide incentives to increase the number of minority graduates, to increase interest in generalist careers, and to improve geographic distribution.
- assist educational institutions in expanding their primary care capacity and in improving the quality of primary care education.

The proposed physician workforce legislation:

- articulates the year 2000 workforce goals which were identified above
- mandates funding of graduate medical education (GME) by all payers
- establishes a National Physician Workforce Commission
- limits total funded residency positions to the number of 1993 US medical school graduates plus 10%
- allocates the reduced number of GME positions to medical school coordinated consortia
- provides transition payments to hospitals most effected by the loss of resident physicians
- provides incentives to individuals and institutions designed to graduate more minority physicians and generalists, to improve geographic distribution and to build primary care teaching capacity

The Council recommends that all third party payers explicitly pay for GME. Graduate medical education is largely funded by teaching hospitals from their patient care income. Both the total payment and accounting of GME funds remain unclear and are poorly coupled with physician workforce requirements. Furthermore, as teaching hospitals increasingly compete with non-teaching hospitals for participation in low cost health care plans, funding of GME may become increasingly difficult.

A centerpiece of the COGME proposal is that funds and slots would be allocated through medical school coordinated GME consortia. These consortia would function as "accountable education partnerships." Each consortium would include one or more medical schools and a diverse spectrum of representatives of institutions which train physicians, utilize their services, or represent the public. Each consortium, coordinated by a medical school, would collectively determine the specialty mix of residency positions based on local, state and regional health care needs under broad national guidelines which specify the number of residency positions and mandate that 50% of graduates be generalists. Consortia would help integrate undergraduate, graduate and continuing physician education and make the educational system more responsive and accountable to public needs. Many consortia are already operating despite the absence of supportive policy.

The Physician Workforce Advisory Commission is central to the proposal. In addition to its advisory role in implementing legislative goals, the Commission would be responsible for monitoring workforce trends, workforce needs, and recommending necessary ongoing modification of goals to Congress and the Health and Human Services Secretary.

COGME believes that its legislative recommendations will achieve year 2000 goals in a timely and predictable fashion. The consortium approach will minimize federal or state government micromanagement and maximize private sector input and creativity. Incentives for individuals and for institutions will assist in the transition, helping new physicians and the medical education system respond to changing demands of the health care market place.

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Consultant support to the Council and Advisory Group on Graduate Medical Education Policy

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for his pivotal report to the Council,
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RESPONSES OF DR. COLWILL TO QUESTIONS SUBMITTED BY SENATOR DOLE

Question No. 1. You have suggested, wisely I believe, that a great deal of decision making regarding specialists and residencies, must take place at the local level. However, once your consortia have made the decision as to how many of a particular group are to be trained in that area, how do you keep them there?

Answer. Residency positions, as you have implied, would be allocated on a formula basis to consortia. These consortia of a medical school, teaching hospitals, and other organizations participating in graduate medical education would develop from natural affiliations, the majority of which already exist. At the local level, the consortia would allocate residency positions to the various specialties in the various institutions under national guidelines to achieve a 50/50 mix of generalists and specialists.

Graduates of these programs would have a higher likelihood of staying in that region than if they were educated elsewhere. Numerous studies over the years have demonstrated that physicians tend to settle in the region where they were educated. For example, approximately 70–80% of physicians can be expected to settle in a state if they grew up in the state, attended medical school in the state, and subsequently completed residency training in the state. Roughly one third will stay in the state of residency training if they have no other roots to the state.

If a region has no training programs, few attractive features, and is economically weak, a shortage of physicians is highly likely. In virtually all nations, the most rural areas have physician shortage. Placement of physicians in these areas must be addressed through incentives and through programs such as the National Health Service Corps.

Question. No. 2. In your opinion what, besides money, interests residents in locating in rural or inner-city areas?

Answer. A rural background and an inner-city background both are predictors of practice in these locations. Educational programs in these locations also may stimulate individuals to practice in these areas. Finally, as noted above, incentives may be necessary such as loan forgiveness.

Question. No. 3. International medical students (IMG) fill approximately 21 percent of the residencies nationwide. It is my understanding that in New York State they fill 42 percent of the residencies. If we are to limit the total numbers of residencies, what would you suggest with respect to these physicians? Who makes the choice between U.S. grads and foreign grads?

Answer. COGME recommends that all physicians, regardless of where they obtained their medical school education, should compete for the limited number of residency positions. Each residency program would select the best qualified applicants for their positions.

Question No. 4. It is my understanding that your organization has selectively identified specialties that are a particular problem; for example, cardiology. But specialties like rehabilitation medicine and general surgery may well be in short supply. Can't we help you target the areas where the problems are?

Answer. COGME believes that decisions about allocation of positions to individual specialties should be made at the local level within each consortium based upon quality of educational programs and local needs. While COGME believes that the resultant allocation of positions is unlikely to unduly harm any specialty, it does provide a mechanism for addressing inadequate numbers of positions within individual specialties should this occur. COGME recommends careful monitoring of the allocation of positions by specialty. In the event of shortage, incentives could be provided to increase positions in those specialties. Alternatively, additional positions could be allocated to these specialties from the national level.

In conclusion, COGME believes that the nation is moving toward a progressive physician surplus with a relative shortage of generalists. As the proportion of the population in managed care increases with its lower utilization of physicians services, the oversupply in the fee-for-service sector will be magnified. Underemployed physicians represent a poor investment in graduate medical education by this country. Federal funding of graduate medical education should fund only the number of physicians needed and should address the desired specialty mix. COGME recommends that the number of residency positions be limited to 110 percent of U.S. medical school graduates and that half of these positions be in the generalist specialties. A reconstituted Council on Graduate Medical Education is essential to monitor trends and make mid-course modification in goals based upon further changes in the health care system, increasing medical capabilities, and local needs.

PREPARED STATEMENT OF DEBRA J. FOLKERTS

Good morning Mr. Chairman and members of the Committee, I am Debra J. Folkerts, ARNP, a family nurse practitioner from Manhattan, Kansas. I am a member of the Kansas State Nurses Association and the American Nurses Association.

The American Nurses Association Associating (ANA) is the only full-service professional organization representing the nation's 2.2 million registered nurses, including staff nurses, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists, through its 53 state and territorial nurses associations.

I am also testifying today on behalf of the:

American Association of Colleges of Nurses, representing 456 senior colleges and universities with baccalaureate, master's, and doctoral nursing education programs across the United States;

American Association of Critical-Care Nurses, the largest specialty nursing association in the United States with over 78,000 members who are dedicated to the welfare of people experiencing critical illness or injury;

American Organization of Nurse Executives, representing 6,000 nurse executives and managers in 120 chapters nationwide;

Association of Operating Room Nurses, Inc., the professional organization of 48,000 perioperative nurses dedicated to enhancing the professionalism of perioperative nurses, promoting standards of perioperative nursing practice to better serve the needs of society and providing a forum for interaction and exchange of ideas related to perioperative health care;

Association of Spinal Cord Injury Nurses, a professional association representing 1,500 nurses involved in the specialty of spinal cord injury nursing;

Emergency Nurses Association, the voluntary membership association of over 21,000 professional nurses committed to the advancement of emergency nursing practice; and the

National Nurse Practitioner Coalition, a group of nurse practitioner organizations who advocate for universal access to basic health care and the removal of barriers to consumer access to nurse practitioner care.

I appreciate the opportunity to testify today on graduate nursing education and other implications of health care reform on those who provide care. As you know, the health care industry is the nation's third largest employer; it accounts for one-seventh of the nation's economy and has been the largest creator of new jobs since 1980. Clearly, major shifts affecting this industry will have great implications for our nation.

To move ahead with health care reform without anticipating the impact it will have on the current industry workforce would be like writing only the first act of a two-act play. We cannot afford to wait until a new health care structure is set up to find out whether we have the qualified persons to deliver promised services. We commend you for seeking answers to one of the most critical questions in health care reform: will the skills of the nation's health care workers match the needs of the system?

Access to high quality, affordable health care is of concern to millions of Americans—not only to the over thirty-seven million who are uninsured, but to the growing number of currently insured who fear that changing or losing their jobs will result in loss of coverage or that skyrocketing costs will make their dependent's coverage or their own out-of-pocket health care costs unaffordable.

America's 2.2 million registered nurses deliver many essential health care services in the United States today in a variety of settings—hospitals, nursing homes, schools, home health agencies, the workplace, community health clinics, in private practice and in managed care settings. Nurses know firsthand of the inequities and problems with our nation's health care system. Because we are there—twenty-four hours a day, seven days a week—we know all too well how the system succeeds so masterfully for some, yet continues to fail shamefully for all too many others.

Nurses see people on a daily basis, who are denied or delayed in obtaining appropriate care because they lack adequate health insurance or are unable to pay for care. These people often postpone seeking help until they appear in a hospital emergency department with an advanced stage of illness or with problems that could have been treated earlier in less costly settings, or more appropriately, prevented altogether with earlier treatment or prevention services.

Our country needs a health care system that makes universal access a reality, that effectively contains costs and that maintains and improves quality. We need a system that stresses primary care and prevention and that unleashes the great potential of nurses and other health care professionals to provide these services.

Nursing is committed to supporting and implementing initiatives that fully address these key issues. We are very encouraged that many of these issues have been addressed by the President's Health Security Act, and Senator Wellstone's health care plan, Senator Chafee's proposal, and other comprehensive health care reform initiatives.

All available health care professionals must be fully utilized in order to achieve universal access. Advanced practice nurses—nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists—are already prepared to provide primary care and specialized services, but barriers to their full utilization must be lifted if the goals of health care reform are to be met.

GRADUATE NURSING EDUCATION

Nursing commends the Congress and the Administration for its increased focus on nurse education issues. It is clear that the United States health care system has an increasingly urgent need for primary care providers. Funding must be made available to strengthen existing advanced practice nurse programs and to establish new programs to prepare the primary care providers so urgently needed.

Data indicates that there is a need to increase primary care providers to meet the health care needs of all Americans. The Administration's plan would shift the funding under Graduate Medical Education from specialty physicians to primary care physicians. Advanced practice nurses will also be increasingly needed to fill the future gap created by this shift to primary care providers as well as in some specialty areas.

We are pleased that President Clinton's health care reform proposal, *The Health Security Act*, contains a provision for funding for graduate nurse education. This would provide a stable, on-going revenue source to expand the production of advanced practice nurses, a vital resource to meeting health care needs. Advanced nurse education includes the preparation of nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetists. These advanced practice nurses are prepared as expert clinicians to deliver primary care and other services vital to America's health care needs. As health care reform reshapes our health care delivery systems, it will be essential to ensure that there is an adequate supply of advanced practice nurses to meet the needs of universal coverage.

The expanded role of nurses including advanced practice nurses, in a reformed health care delivery system is critical to ensuring access as well as delivery of needed health care services to all populations, including the underserved. An important element of most health care reform proposals currently pending before Congress is the emphasis on preventive and primary health care services. These services have been at the very center of nursing practice since the inception of the profession.

Nurses are well-positioned to fill many of the current gaps in accessibility and availability of primary and preventive health care services. Advanced practice nurses are trained to provide from 80 to 90 percent of the necessary primary care services of the nation. Primary care services include: preventive care and screening, physical examinations, health histories, basic diagnostic testing, diagnosis and treatment of common physical and mental conditions, prescribing and managing medication therapy, care of minor injuries, education and counseling on health and nutrition issues, minor surgery or assisting at surgery, prenatal care and delivery of normal pregnancies, well-baby care, continuing care and management of chronic conditions, and referral to and coordination with specialty caregivers.

Of the 2.2 million registered nurses in the United States, approximately 90,000 are considered advanced practice nurses with advanced education and training in providing primary care. This training includes an advanced certificate or degree beyond the four-year Bachelor of Science degree. Of the total advanced practice nurses currently in the workforce, about 50 percent are engaged in primary care.

Today, there are approximately 25,000 nurse practitioners practicing—most of whom are engaged in the delivery of primary care services. Most of the 150 nurse practitioner programs in the United States grant a Master's degree. Nurse practitioners can write prescriptions in 35 states.

Most of the 40,000 clinical nurse specialists currently practicing are in the areas of cardiology, mental health, cancer care or neonatology. Other clinical nurse specialists are case managers in the care of chronic health conditions such as diabetes, or health and nutrition educators and work in a primary care health setting. Clinical nurse specialists have often earned their master's or doctoral degrees in their specialty areas of practice. As the hospital workforce shifts to a lesser dependency on medical residents, hospital administrators are depending on the use of advanced practice nurses, such as nurse practitioners and clinical nurse specialists, to fulfill

many of the responsibilities once undertaken by the medical residents. This workforce is critical to the continuing acute care operations of many hospitals.

In addition to the above advanced practice nurses, there are certified nurse midwives who are engaged in prenatal and gynecological care as well as the delivery of babies. Most certified nurse midwives receive 12 to 18 months advanced training above their basic education. Certified registered nurse anesthetists receive a graduate education approximating 27 months of which the first nine months are spent in the classroom with the remaining 16 months spent in clinical training.

Extending health care coverage to the 37 million Americans currently uninsured will increase the demand for primary care services beyond the level it is expected to grow under the current health care system. Programs are needed, however to provide the education necessary to prepare these professional nurses to provide the necessary care. President Clinton's *Health Security Act* includes a provision which proposes a stable dedicated revenue stream for graduate nurse education. This funding would provide a reliable revenue source that is not subject to the annual appropriations process to expand the current production of advanced practice nurses. The nursing community is working with the Department of Health and Human Services to determine how the new program could be operationalized.

Representatives of major nursing organizations have agreed on a set of criteria that we believe should guide the formation of a graduate nursing education program. The criteria are as follows:

- The funding focus should be on educational support for advanced practice nursing students;
- Graduate Nurse Education funds should not be used to support undergraduate nursing education;
- The Graduate Nurse Education fund should have a dedicated funding stream to provide monies in addition to the currently available nursing and allied health funds under the graduate medical education program which is used largely to support nursing diploma programs;
- Funding through a Graduate Nurse Education must be in addition to current authorizations under Title VII and Title VIII of the Public Health Service Act. The later would provide the necessary infrastructure for the Graduate Nurse Education program and would ensure that there is an adequate supply of faculty and researchers;
- Students eligible for the Graduate Nurse Education funds should be post-baccalaureate, advanced practice nursing students enrolled in a program that is linked to an academic institution; and
- All educational programs that incur costs for support of advanced practice nursing education will have access to the Graduate Nurse Education monies for student stipends, costs of clinical nursing faculty supervision at the clinical sites, and program expenses including salaries of support staff. Clinical sites include nursing centers, hospitals, ambulatory care facilities, and home health agencies;
- Classroom costs incurred by rural and urban underserved providers that have agreements with academic institutions should be reimbursed.

The Graduate Nurse Education program would help many graduate nursing students who are currently attending school part-time due to financial constraints to become full-time students. The current cost of attaining a nurse practitioner education is similar to students pursuing master's degrees in other areas of study. The American Association of Colleges of Nursing found that based on 1988 dollars, its costs a graduate nursing student about $36,837 without financial aid to receive a master's degree.

A large portion of a graduate nursing student's programs is in clinical practice. Some certifying exams require the graduate to spend one-third of his or her advanced nurse education experience in the classroom and two-thirds in clinical practice, although in most all cases, the classroom and clinical studies are integrated throughout the graduate student's curriculum. In other words, even as advanced practice nurses are training for their degrees, their services are utilized in providing much needed health care services.

Study after study demonstrates that advanced practice nurses are an essential means to providing health care services in a cost efficient manner and to underserved populations. Preliminary data from a study being conducted at the University of Wisconsin under a Robert Wood Johnson grant show that when nurse practitioners are utilized by health maintenance organizations (HMOs), the need for physicians decreases from 30 to 50 percent. The data also show that the inclusion of nurse practitioners on the patient care team doubles the efficiency of that team. Another recent survey (*Survey of Beneficiaries of Nursing Education Projects*, December 1993) found that 90 percent of nurse practitioner and certified nurse midwife

graduates are engaged in direct patient care. Of those nurses surveyed, more than 60 percent provide maternal and child health care; 25 percent are involved with caring for the homeless; 40 percent provide care to the elderly; and 28 percent care for HIV infected individuals.

The advanced practice nurse is a vital component to increasing access to quality health care services in a reformed system. The costs of preparing the advanced practice nurses are currently borne almost entirely by schools of nursing and the students themselves, each with very limited resources. In order to quickly expand the numbers of these expert clinicians, there must be an increased Federal commitment to graduate nursing education. Investment in the Graduate Nurse Education program will ensure that advanced practice nurses are able to meet the needs of a reformed health care system.

MEDICARE AND MEDICAID REIMBURSEMENT

Education programs for advanced practice nurses alone, however, will not solve nursing's ability to provide full primary and preventive health care services. The ability of nurses to provide health care services has been continually hampered by a number of artificial barriers that serve to cut the consumer off from access to services provided by these competent and qualified health providers. Factors such as artificially depressed wages, lack of third party reimbursement policies by Federal and state programs and private insurers, limitations of State nurse practice acts, the unavailability of malpractice insurance and institutional opposition to nurses practicing to their full legal scope of practice have had a major negative impact on the ability of advanced practice nurses to fully practice within their educational parameters. The fastest way to expand the number of advanced practice nurses in this country would be to eliminate the barriers to practice and reimbursement which prevent these nurses from practicing to their fullest capability.

The laws regarding reimbursement for advanced practice nurses are extremely complicated and convoluted as to which categories of advanced practice nurses may be reimbursed, in what geographic areas, who may be paid and whether or not collaboration with other health providers is required. The current laws are so confusing and complex for carriers, providers, and consumers that they have become a barrier to access to these services in and of themselves.

The Health Security Act goes part way in guaranteeing that barriers to health care for the nation's elderly are removed. ANA was pleased to have the opportunity to work closely with Senator Tom Daschle (D-SD) and other members of this Committee to achieve enactment of the *Rural Nursing Incentive Act*. That provision which was included in the *Omnibus Budget Reconciliation Act of 1990* (Public Law 101–508), enables nurse practitioners and clinical nurse specialists who practice in rural areas to receive direct reimbursement under Medicare. *The Health Security Act* expands this provision by allowing Medicare reimbursement for all nurse practitioners and clinical nurse specialists, regardless of the geographic settings, but inhibits the practice of some advanced practice nurses by setting artificial barriers on the practice setting and the association of the advanced practice nurse with another health care provider. Under *The Health Security Act*, Medicare reimbursement would not be allowed for nurse practitioners and clinical nurse specialists for in-hospital settings and all advanced practice nurses would have to demonstrate collaboration with a physician to be eligible for any Medicare reimbursement. We believe that these restrictions will significantly hamper the ability of the advanced practice nurses to provide their services to the elderly.

Legislation (S. 833) has been introduced by two members of this Committee, Senators Charles Grassley (R–IA) and Kent Conrad (D–ND) to remove all arbitrary restrictions from Medicare reimbursement for advanced practice nurses and better serve the needs of the nation's elderly. In addition, modeled after the current program of bonus payments to physicians who work in health professional shortage areas, this legislation would extend a bonus payment to advanced practice nurses when they work in health professional shortage areas. This provision is designed to encourage non-physician providers to relocate to areas in need of health care services. Extending bonus payments to non-physician providers has also been recommended by the Physician Payment Review Commission. We endorse this legislation.

Another example of payment inequities for nurses under the Medicare system is the lack of reimbursement for operating room nurses serving as assistants at surgery. The issue of Medicare reimbursement for registered nurses who assist at surgery has been an important issue for ANA and the Association of Operating Room Nurses since a provision was included in the *Omnibus Budget Reconciliation Act of 1986* that permitted reimbursement for physician assistants who first assist at sur-

gery, but not for registered nurses who have functioned as first assistants for decades and are reimbursed by many private payors. The ability of physician assistants to be reimbursed under Medicare has created employment disparity for nurses who provide the same service, but are not reimbursed under the law. Legislation (H.R. 1618) has been introduced in the House of Representatives to permit direct payment under the Medicare Program for the services of registered nurses as assistants at surgery. We support this legislation.

In addition to the access problems confronted by our senior citizens, many Medicaid recipients are also being forced to forego essential health care services because health care providers are not available to them. In order to improve access to care under Medicaid, certain reforms in payment and coverage policy must be enacted by the Congress. At the present time, the Federal Government mandates that states provide for direct Medicaid reimbursement of certified nurse midwives, certified pediatric nurse practitioners and certified family nurse practitioners. However, it does not mandate the coverage of services furnished by other nurse practitioners, or by clinical nurse specialists and certified registered nurse anesthetists. Some states have opted to cover the services of additional nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists. Other states have chosen not to include services of advanced practice nurses beyond the Federal mandate. This means that access to services for many Medicaid recipients remains limited despite the availability of professionals who are willing and qualified to provide services to them—such as women's health nurse practitioners, gerontological nurse practitioners and others. The Medicaid program needs to directly reimburse for the services of all advanced practice nurses so that they may be utilized by Medicaid recipients. This is a step that can be taken to increase access immediately.

Senator Tom Daschle (D–SD) has introduced a bill (S. 466) to improve access to the services of nurse practitioners and clinical nurse specialists by mandating the coverage and payment of all nurse practitioner and clinical nurse specialist services under the Medicaid program. An identical bill (S. 1683) has been introduced in the House of Representatives by Representative Bill Richardson (D-NM). The Congressional Budget Office has estimated that the cost of enacting this proposal would be $46 million over a five-year period. That is a very small amount when compared to the value of increasing the access of Medicaid recipients to badly needed health care services.

In addition to the general examples of barriers to practice just noted, there are three specific Medicare reimbursement barriers to practice that exist for certified registered nurse anesthetists (CRNAs). First, the current Medicare conditions of payment for anesthesiology services that anesthesiologists must meet in order to be paid for Medicare for medically directing a CRNA, restrict CRNAs from performing all the components of an anesthesia service that they are legally authorized to perform. For example, some anesthesiologists insist on performing the anesthesia induction on all patients themselves, then leaving the CRNA to finish the case. Second, the current Medicare hospital condition of participation for anesthesia services and the Medicare ambulatory surgical center condition of participation for coverage for surgical services restrict CRNA practice by requiring physician supervision of CRNAs. Third, the current Medicare regulation on payment for the services of CRNAs states that if a CRNA and anesthesiologist work together on one case, the anesthesiologist may bill the case as if he/she personally performed it and receive 100 percent of the Medicare payment. No Medicare payment is typically made to CRNAs involved in such a case, even if the CRNA was the provider actually administering the anesthesia to the patient.

Just as nurses throughout the United States have demonstrated their ability to provide high quality, cost effective and accessible health services, consumers have shown their widespread acceptance of these services and their willingness to continue receiving primary care services from nurses. A recent Gallup poll revealed that the vast majority of Americans (86 percent) are willing to receive everyday health care services from an advanced practice registered nurse that they now must go to a physician to receive. Only twelve (12 percent) percent said they would be "unwilling" to go to a registered nurse. Nurses are currently working with consumer-oriented organizations in order to promote shared principles of health care reform. We are confident that as the American public becomes more familiar with the primary care services that nurses can provide, and as more Americans have an opportunity to receive such care from nurses, that the "unwilling" category will decrease sharply. In fact, we believe that, based on the experiences of advanced practice nurses in HMO, clinic, and private practice settings, more and more Americans will identify nurses as their provider from whom they select to receive primary care services.

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REMOVING BARRIERS TO PRACTICE

One of the key features of the Administration's proposal is the elimination of anti-competitive practices in the health care industry to ensure that health providers are treated equitably within the health system by removing barriers to practice. In discussing how this can best be achieved, nursing has stressed aggressive enforcement of antitrust guidelines and a reiteration of its commitment to encouraging competition in the health care marketplace.

Nursing is concerned with aspects of the Administration's proposals for establishing fees in a reformed health care system Nursing opposes the broad antitrust exemption contained in Section 1322(c) of that proposal. This provision which would permit providers to negotiate collectively with alliances (or states) over the fees paid under any fee-for-service schedule, does not assure that nurses and other nonphysician providers would participate equally with physicians in such negotiations. Without assurances of such equal participation, nonphysician providers could be placed at a serious competitive disadvantage by this provision, and ultimately, consumers would suffer as well, since their access to nonphysician providers would be artificially limited and the prices paid for physician services could be too high. In short this exemption, as presently drafted, could exacerbate two of the most serious problems with the current health system.

In addition to violations of the antitrust laws, there are other anticompetitive barriers that prevent the optimal use of nurses. For example, restrictive language in state laws and regulations that determine the scope of nursing practice prevents nurses from offering many services that they are clinically competent to provide. Legal requirements that nurses perform certain services only under the "supervision of," or "in collaboration with," physicians, are examples of such anticompetitive barriers. These supervision or collaboration requirements are often found in the state laws prohibiting or drugs appropriate to their scope of practice. Other anticompetitive barriers faced by nurses include the lack of direct reimbursement for nursing services in many settings, the unavailability of malpractice insurance, and the barriers to obtaining institutional privileges. These barriers not only prevent nurses from practicing fully; they provide pretexts for health plans not to hire nurses.

Nursing encourages this Committee to develop a new health system that will compel all business entities to treat all health providers in accordance with the legal scope of their practice and will review all actions taken by corporations working within a health plan, especially when they adversely impact one class of health professionals.

CONCLUSION

Mr. Chairman, we support health care reform that provides universal access to care, and balances the need to contain costs with the need to provide quality health services. We have always endorsed the use of the most appropriate provider to meet the consumer's health care needs in every setting. We applaud this Committee for its strong commitment to developing a health care system that provides access to quality, affordable health care. As your deliberations proceed, we urge you to continue to address the education and reimbursement needs of the health care workforce. The system cannot succeed without skilled nurse providers.

We appreciate this opportunity to share our views with you and look forward to continuing to work with you as comprehensive health care reform is developed. Thank you.

RESPONSES OF MS. FOLKERTS TO QUESTIONS SUBMITTED BY SENATOR DOLE

Question No. 1. There is a clear desire on the part of many to move away from fee-for-service as a method of payment, yet you strongly argue for fee-for-service for many nurses. Row can we achieve your goal of equality without fee-for-service?

Answer. It is true that many wish to move away from fee-for-service payment and, in fact, there is already a significant trend away from this form of payment toward capitated and similar payment arrangements. Nursing recognizes this trend. Our call for making payment available for advanced nursing services under fee-for-service arrangements is not motivated by a commitment to this form of payment over all others. It is our belief that where fee-for-service payment is available for health care professionals' services, such payment should be available to advanced practice nurses on the same basis as it is to other providers, such as physicians. A clear example of this is in payment for services provided under Medicare Part B. Such payment remains largely fee-for-service, and is unavailable for most services of advanced practice nurses in non-rural areas. One key to providing accessible, high-

quality, and cost-effective services to the Medicare population is allowing advanced practice nurses to be paid for providing such services to them.

At the same time, there must be coverage for services provided by advanced practice nurses under capitated and other managed care arrangements. The record here is uneven. In many staff-model HMOs, for instance, advanced practice nurses are utilized to provide a broad range of primary health services to plan members. In many other managed care organizations, such as PPOs and IPAs, advanced practice nurses have been wholly excluded, as a class, from membership on provider panels. This has completely eliminated these providers from these plans and made it impossible for plan members to obtain their services.

Nursing has advocated antidiscrimination measures that would prevent managed care organizations from discriminating against any class of health care professional that provides covered services. The discrimination against whole classes of providers serves only to inhibit competition among health care providers.

Question No. 2. We are currently concerned with the inappropriate distribution of primary care physicians versus specialists. While 50 percent of the nurse practitioners are currently engaged in "primary care"—what is to prevent nurses from shifting to more institutional or specialty pro? As I understand it, a declining number of physician assistants are choosing primary care as a practice area?

Answer. First, while most advanced practice nurses seek careers in primary care, many do, in fact, specialize. Unlike in medicine, specialization in nursing does not generally lead to greatly increased levels of compensation. For many, it is simply a matter of where positions and funding are currently available. As medical education shifts to a greater focus on primary care, there will be a continued and expanded need for advanced practice nurses in hospitals, and particularly in specialty areas, to provide services that are currently furnished by physician residents.

But many, many advanced practice nurses seek their advanced education precisely it offers an opportunity to function as a primary care provider. Many nurses feel that this is a logical extension of the fundamental role of the nurse in addressing the needs of the whole person. Primary care is a field that is very attractive to many nurses because of its emphasis on assessing and managing a patient's needs and working closely with patients over a long period of time. Whereas physician assistant practice is based on the practice area of the supervising physician, advanced practice nurses are educated to practice independently and are not constrained by the career paths and choices of physicians.

Question No. 3. Ms. Folkerts, I would appreciate your telling us about your own personal experience in servicing a rural county and working with physicians ad others. How do you set-up collaborative relations?

Answer. I am a product of the rural area where I have practiced for ten years. I attended a certificate Nurse Practitioner Program in 1983 in Hays, Kansas. This program was run as a satellite of Kansas University and designed especially for rural areas. The structure of this program facilitated establishing collaborative relationships. Students were required to be in Hays for three days every two weeks for classroom instruction. The remaining days were spent with the precepting physicians. In my case, this allowed me to have as preceptors physicians who practiced in my own rural community. I established collaborative relationships and worked side-by-side with the physicians in the community where I would be practicing as an advanced practice nurse. The preceptorship resembled a medical residency in that the student "shadowed" the preceptor for one year ad shared In the long hours, emergency calls, etc.

The physicians whom I worked with served a four-county area. This fact also provided me opportunities to establish collaborative relationships with physicians in those counties.

In 1990 the physician whom I worked with relocated to Colorado. At that time, I knew a physician in a near-by town who was retiring. He was the sole provider for a community of 600 people; it included a 40 bed nursing home. This physician thought that his practice was perfect for me. I was able to establish collaborative relationships with two physicians who had served as preceptors for me during my training, and I began to practice at the Glasco clinic. The town was pleased to have continued access to health care services. Sixty-eight percent of my patients were Medicare beneficiaries.

I faced numerous challenges as a rural practitioner. Many of my patients had no means of transportation. The science of physical examination became an art because I did not have the luxury of an x-ray machine to diagnose congestive heart failure. I was able to establish service with a mobile ultrasound service to come to the clinic once a week to do some procedures. I used a courier lab service.

Among my patients, the most common diagnoses were congestive heart failure, diabetes, and hypertension, all of which require close monitoring. I supplied many pa-

tients with their medications from drug samples. The ability to establish a Rural Health Clinic was instrumental in allowing me to continue to provide services to a population with a large percentage of Medicare beneficiaries, since office visits accounted for the majority of the revenue.

When I practiced in Glasco, the relationships I had nurtured during my preceptorship were again helpful. Physicians in four counties accepted my referrals ad readily provided consultation. I had excellent rapport. Hospital privileges also came easily because of the support I had from the physicians.

Once a collaborative relationship has been established, I have found that the physician continues to promote nurse practitioners. Dr. Carl T. Newman of Denver, Colorado, is the first collaborative physician with whom I practiced. He is currently working with a hospital to provide urologic managed care in Denver. His strategy is to use nurse practitioners to screen and treat chronic and acute patients. I continue to consult with him regarding roles ad strategies.

In summary, I believe that the role of the Nurse Practitioner must be understood in order for collaborative relationships to be established. One way to achieve such understanding is to train nurse practitioners and residents side-by-side in some segments of their education. An alternative would be to ensure that students receive their education and preceptorships in the communities where they wish to provide service—as happened in my case. I strongly believe that programs to educate nurse practitioners need to be established in the rural areas where the providers are needed. People who are interested in serving in rural areas tend to be from those areas. In the case of nurses ad nurse practitioners, many are women. They have families in rural areas and cannot leave those areas to continue their education; but for the same reason, i.e., their ties to the rural community, individuals from those areas who do complete nurse practitioner programs are committed to returning to, or staying in, those areas. Satellite programs can be particularly effective in educating more rural providers.

Question No. 4. We are thinking of changing the way we reimburse for medical education and moving the funding away from institutions that encourage inpatient versus ambulatory care. Where do most advance practice nurses receive their education now? What is the best way to provide funds to your colleagues—through grants and loans or some other way?

Answer. The majority of nurse practitioners currently receive their education in graduate programs that award a master's degree.

The best way to provide funds to nurse practitioners is through a combination of grants for the development of programs, such as those provided for in Title of the Public Health Service Act, and funding for students through a Graduate Nursing education program. This combination is critical; students cannot attend programs that do not exist; and they cannot go to school if they are unable to pay tuition and living expenses.

Historically, nursing education has not been driven by the same force driving graduate medical education, namely, providing services to hospitals. In those instances where nursing education has been used primarily to provide staff to hospitals, as in diploma schools of nursing run by the hospital, the nursing programs have not generally been among the academic leaders of the profession.

Nursing education needs to be based primarily in educational *programs* (as opposed to *institutions*) that have strong linkages to clinical training sites in the community. The combination of program support and GNE funds to students, with some mechanism to direct the funding according to public need, is the right approach.

The nurse practitioner movement itself is an excellent example of how federal funding has created a new group of providers. In the past twenty-five years, thousands of nurse practitioners have been educated, thanks in large part to federal financial support. Federal policy, backed by federal dollars, has produced providers oriented toward primary care. This approach has worked better than a more laissez-faire orientation of funding practice sites, primarily hospitals and acute care settings.

Question No. 5. In November of 1992, a Task Force on Barriers to Practice for Non-Physician Providers prepared a report identifying several areas of concern. Among these areas were liability and malpractice insurance issues. I know in our own state of Kansas the cost of malpractice, particularly for OB-GYN's, has been a real problem.

How much of a problem is malpractice insurance for nursing professionals like yourself? Are you and "added liability" for physicians you work with?

Answer. Nationwide, nurse practitioners have access to malpractice insurance at a fraction of a physician's cost. Currently my malpractice premium is $640.00 per year for coverage of $1,000,000 per claim per year and $3,000,000 total per year.

I know of no situation in which a physician paid more for insurance coverage due to his collaboration with a nurse practitioner.

In Kansas the Practice Act for nurse practitioners states that we are directly responsible to the patient for our professional actions. I therefore do not believe that I am an "added liability" for any physician or other professional whom I work with, since I am legally responsible and accountable for exercising my own professional judgment in providing care.

PREPARED STATEMENT OF SENATOR ORRIN G. HATCH

Mr. Chairman: I will keep my remarks brief, but I just want to make a couple of observations.

First, it is clear to all of us that we have too many physicians in specialties, and too few in primary care. Estimates are that one-third of American physicians practice primary care; in other countries, such as Canada, that number approaches 55 percent.

Second, it is equally clear that there are serious imbalances in where health professionals are practicing.

This Committee has always been especially sensitive to the needs of rural America. It is crucial that we maintain—I venture to say, even heighten—this sensitivity, as our debate on health care reform unfolds.

I tend to agree with our colleague, Senator Kassebaum, who has called this the "sleeper issue" in health care reform.

Medicare pays $5 billion annually to teaching hospitals, so it is obvious that the federal government has a role to play here.

What is not obvious to me is that the federal government must reach down and, in effect, set arbitrary quotas for medical school enrollment. Rather, I think the Committee should direct its efforts toward setting a rational policy that will enhance naturally evolving trends that call for greater and greater numbers of primary care practitioners.

This hearing will be helpful to the Committee in meeting that goal, and I want to welcome our witnesses today.

PREPARED STATEMENT OF CLAYTON E. JENSEN

COMMUNITY-BASED MEDICAL EDUCATION IN HEALTH CARE REFORM

1. Introduction

Chairman Moynihan, Senator Conrad and other members of the Committee on Finance of the United States Senate, I am deeply honored to appear today to present testimony on health care reform. I am Clayton Jensen, M.D., interim dean of the School of Medicine of the University of North Dakota (UNDSOM) and chairman of the Department of Family Medicine. I am a family physician and came to my current positions after 25 years of primary care practice in Valley City in east-central North Dakota. Valley City has a population of 7163 and is situated on the Sheyenne River in a beautiful, rural setting. There are 635,000 people in the State of North Dakota.

The School of Medicine of the University of North Dakota congratulates this committee on your recognition of the need to consider the perspective of rural America and of community-based medical schools as you wrestle with health care reform. We believe the model of medical education that we are successfully implementing in North Dakota offers important lessons for other schools and, when appropriately supported, is uniquely able to address health care work force needs of our region.

2. An Overview of UNDSOM

We are a small school. A typical entering class has 57 students, 7 of whom are American Indians (12 percent). Most of our students are from North Dakota and surrounding states. Although we started as a two-year school in 1905, we converted to M.D. degree-granting status in the late 1 970s. We graduate approximately 55 physicians per year. We have four family practice residency sites and residency training programs in medicine, surgery and psychiatry.

UNDSOM is a community-based medical school. We have affiliation agreements with private and public hospitals, but have no ownership in these hospitals. Most of our clinical faculty are community physicians who enjoy teaching medical students and residents and have been willing to do so for token or no payment. We have four regional campuses and more than 30 preceptorship sites throughout the

region. Approximately 55 percent of the graduates of UNDSOM enter residency training in the primary care specialties of family medicine, internal medicine, obstetrics and gynecology, and pediatrics. For several years, our school has been recognized as a national leader in the percentage of graduates who enter family medicine. In 1993, 27.7 percent of our graduates entered family practice residency training compared to the national rate of 10.8 percent (Appendix One). When UNDSOM was a two-year school, fewer than 20 percent of our graduates returned to practice in the state. Today, about half of the state's physician work force are alumni of UNDSOM. A recent study by Rosenblatt, which appeared in volume 268 of the *Journal of the American Medical Association* (September, 1992, pp. 1559–1565), states:

> *Medical schools vary enormously in the likelihood that their graduates will enter rural practice. The range is from 41.20% of the graduates from the University of North Dakota practicing in rural areas to 2.3%*
>
> *One of the reasons that new state-supported medical schools were created was local legislative concern about the paucity of physicians in rural areas. The data in this article suggest that this was both a rational and effective policy. States like North Dakota that are predominantly rural are unlikely to have very many physicians unless they invest in their own medical education programs.*

Our own data indicate 72 percent of the physicians who complete our M.D. program and also complete our family practice residencies establish practices in North Dakota or in the close-by regions of the states that surround North Dakota.

The curriculum that is utilized by UNDSOM is summarized in Appendix Two. A map of the preceptorship sites is shown in Appendix Three.

3. The North Dakota Center for Graduate Medical Education (NDCGME)—A Model Consortium for Medical Education

The national average direct medical education (DME) reimbursement from Medicare in 1992 was $73,383. The average allowed reimbursement for DME for North Dakota in 1992 was $21,915, a difference of $51,468 (see Appendix Four). This discrepancy, as well as cutbacks in state funding of the UNDSOM family practice residency programs, led to formation of a consortium which is diagramed in Appendix Five. This consortium currently consists of the eight teaching hospitals located in the state's four largest cities. The consortium establishes policy for graduate medical education in North Dakota and has recently agreed to be the recipient agency for graduate medical education funding. The consortium was successful in securing an amendment in the Omnibus Budget Bill passed by the 1992 U.S. Congress. This amendment addresses some of the inequities in the Medicare funding of our residency programs.

4. Financing of Medical Education

UNDSOM is successfully addressing many of the physician work force needs of North Dakota and the region. The curriculum of the school can be improved, in several aspects to improve the training of medical students, residents and other members of the health care team for practice in the region and to increase the likelihood that they will practice in North Dakota.

The major obstacle for accomplishing these goals and for maintaining the programs that have been established is an inadequate funding base.

We strongly support the principle that all payers must support education and training of the workforce as well as providing an environment in which education and clinical research can flourish. Education and training must be supported at actual costs.

5. Community-Based Medical Schools

UNDSOM is one of approximately 25 community-based medical schools. These schools represent a group of primary care intensive institutions that are both integrated with and responsive to their communities. Community-based schools have been shown to be quite efficient in the education and training of primary care physicians. According to data from the latest *AAMC Institutional Goals Ranking Report*, community-based medical schools constitute 10 of the 13 leaders in the production of primary care physicians.

Unique to the collective mission of the community-based medical schools is:

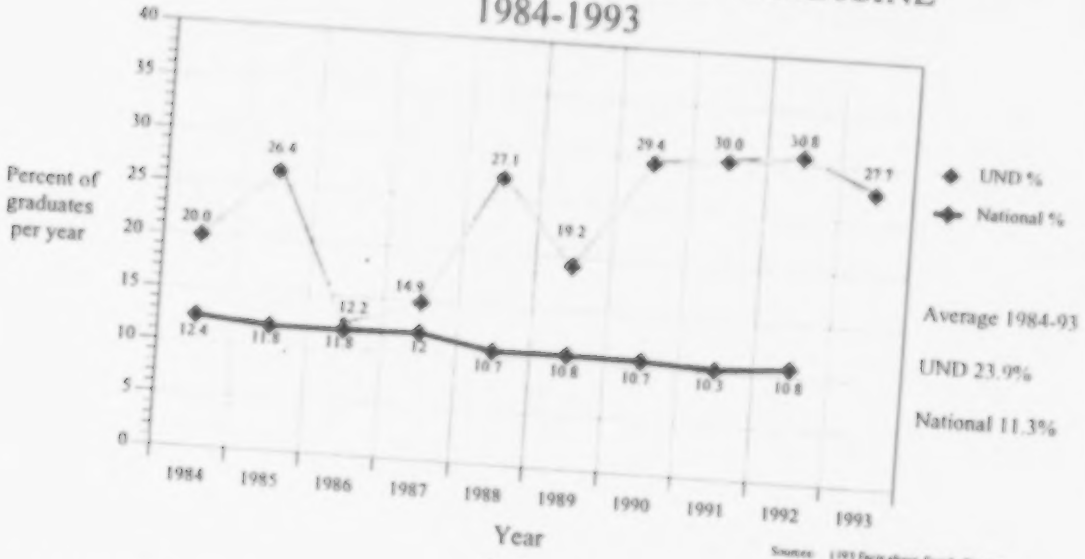
- a primary care focus upon which their education, research and service missions are based;
- a responsiveness to local and regional work force, education and service needs in the rural and urban areas they serve, and

- both the use of and cooperation with community resources to provide education and training, including volunteer physicians and other health care professionals, community hospitals and clinics.

In common with other medical schools, the community-based medical schools support and engage in the advancement of knowledge in behavioral, biomedical, preventive and clinical-outcomes research. Further, each is primarily responsible for undergraduate medical education and assumes a major role in directing or coordinating graduate and continuing medical education for their region.

Representatives from several of the Community Based Schools recently assembled to draft a position statement on several issues raised in the Health Security Act and other health care reform proposals that are being considered by Congress. The position statement is attached as Appendix Six.

UNIVERSITY OF NORTH DAKOTA SCHOOL OF MEDICINE
STUDENTS ELECTING FAMILY MEDICINE
1984-1993



Sources: 1993 Fact sheet: Family Practice
American Academy of Family Physicians

Department of Family Medicine
University of North Dakota

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APPENDIX TWO

UND SCHOOL OF MEDICINE CAMPUSES

MEDICAL EDUCATION CURRICULUM - UNIVERSITY OF NORTH DAKOTA

PHASE I — 2 WEEKS — ORIENTATION

Problem Solving: Primary Care in North Dakota

PHASE II

Year 01: — 36 WEEKS

Biochemistry	Gross Anatomy
Histology and Organology	Physiology
Human Behavior	Neuroscience
	Focal Problems

Grand Forks

Year 02: (Continued) — 35 WEEKS

Pathology	Epidemiology
Pharmacology	Human Behavior
Microbiology	Introduction to Clinical Medicine
	Focal Problems

PHASE III — 3 WEEKS

Introduction: Hospital-Based Practice of Medicine
28 Community Hospitals in-State

PHASE IV — 48 WEEKS

Year 03:

Medicine	Psychiatry
Surgery	Pediatrics
Obstetrics/Gynecology	

33 Students will study on the Fargo Campus
22 Students will study on the Bismarck Campus

PHASE IV (Continued) — 32 WEEKS

Year 04:

Family Medicine Clerkship Required	8 Weeks
Family Physicians' Offices	Statewide
Six 4-Week Electives	

During the fourth year, students will study on one of the four clinical campuses: Bismarck, Fargo, Grand Forks, Minot.

PHASE V — 4 WEEKS

Advanced Clinical Experience

Phase V is the third and final transitional phase in the Medical School curriculum. It is 4 weeks in length and taught in the rural hospitals utilized in the Phase III program. The Phase V students return to the same sites where they participated in Phase III. Prerequisites: Successful completion of the first four phases of the UND Medical School training program. The objectives of this rotation is to prepare the senior medical students for residency training and to act as teachers for the Phase III students.

M.D. Degree: Upon Completion of requirements, Graduation from UND Medical School.

Residency: 3 - 5 years post-graduate training.

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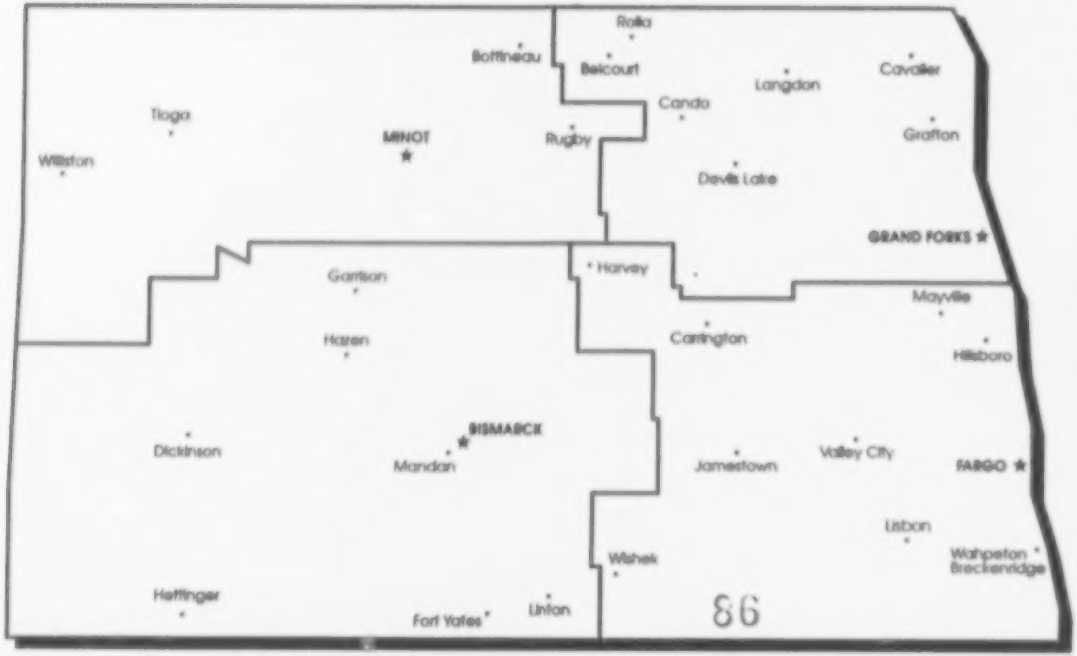
University of North Dakota School of Medicine



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APPENDIX FOUR

UND School of Medicine

Direct Medical Education Reimbursments from Medicare: 1992
North Dakota Teaching Hospitals

	Per Resident
National Average Reimbursement	$73,383
Average Allowed Reimbursement for North Dakota	$21,916
North Dakota receives under 30% of the National Average Reimbursement for Direct Medical Education.	
North Dakota Underfunding from National Average	$51,468
Average North Dakota Medicare Utilization Rate	47.50%
Underfunded reimbursement per Resident	$24,447
Number of Residents at UND School of Medicine	110
Total Underfunding of North Dakota Direct GME	$2,689,203

UND School of Medicine is a national leader in the percentage of its graduates (more than 25%) who pursue Family Practice residency training. More than 80% of UND School of Medicine graduates who pursue Family Practice take their training in UND Family Practice residency training programs. These model programs deserve increased federal support.

North Dakota Center for Graduate Medical Education

Current Responsibilities
1. Policy Issues
2. Governance
3. Funding Level
4. Accreditation Issues
5. Fiscal Agent

Future Responsibilities
1. Number of Residents and Mix
2. H.H.S. Primary Training Goals
3. Recipient of GM Federal Funding
4. Interconsortium Cooperatives

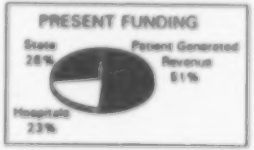
13 Member Board
8 Hospital CEOs
4 Campus Educators
1 Deans Office

NDCGME

Local Consortium

Bismarck	Fargo	Grand Forks	Minot
St. Alexius MedCenter One	St. Luke's MeritCare Dakota Heartland	United	St. Joseph's Trinity
Q & R Clinic Mid Dakota Clinic Independents	Fargo Clinic MeritCare Dakota Clinic Independents	Grand Forks CLinic Valley Medical Independents	Medical Arts Clinic Independents
Campus Educator	Campus Educator	Campus Educator	Campus Educator

Local Consortium Responsibilities
1. Funding- Local Effort
2. Goverance
3. Operational Issues
4. Communications



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APPENDIX SIX

POLICY POSITIONS ON HEALTH CARE REFORM

This document constitutes a draft position statement by the Community-Based Medical Schools on several issues raised in the Health Security Act. The document draws upon the thoughts and writings of other groups including the Association of American Medical Colleges (AAMC), Association of Academic Health Centers (AAHC) and the Academic Health Center Working Group. However, it broadens the principles so as to be more inclusive of the mission of the Community-Based Medical Schools.

The concept of the Academic Health Center (AHC)as referred to in the Health Security Act should be enlarged to include all the relevant teaching institutions that contribute to health professions education in a given region. Thus, we propose to expand on the concept of the AHC which we now refer to as the Medical Education Consortium (MEC).

1. MEDICAL EDUCATION CONSORTIA:

A Medical Education Consortium (MEC) consists of one or more allopathic or osteopathic medical schools, affiliated teaching hospitals and other facilities utilized in the teaching/training of medical students, residents and other health professionals. It may include other health professions training programs as appropriate.

The MEC is the accountable agent for achieving regional health care workforce needs and objectives including, but not limited to, the number of positions in, and specialty mix of, regional residency programs. The MEC may assume similar responsibilities for allocating number and mix of other health professions trainees.

The MEC should receive all training funds associated with programs operating within its auspices. The designation of the responsible fiscal agents within the MEC should be determined by the consortium members.

The MEC will be responsive to community/regional health workforce needs for all health professions.

All training programs must align with at least one MEC.

2. NATIONAL COUNCIL ON HEALTH PROFESSIONS EDUCATION AND TRAINING (NCHPET):

A national council should be established within the Department of Health and Human Services (DHHS) as an advisory body on all health professions education and training. It should make recommendations on how federal funds should be utilized to support primary care and other specialties within medicine as well as other health professions that are determined to be in short supply. The NCHPET

APPENDIX SIX
(continued)

should be formed in such a way as to be responsive to regional and local needs. The membership on the council should be broadly based.

A separate group should be formed to be concerned with the allocation of total GME slots and total GME funds to regional consortia (Medical Education Consortia) based on policy guidelines of the NCHPET. The separate group should be given relief from Federal Trade Commission regulations in order to address health work force needs.

The Medical Education Consortia should be responsible for all GME positions within their regions, including those supported by federal funding and those supported from other funding sources. There should not be federal restriction on GME positions supported by non-federal funds if those other positions are deemed necessary to meet the workforce needs of the consortium.

3. PRIMARY CARE:

There is need for a shift to a better balance among primary care and specialty physicians approaching a 55:45 ratio, or such ratio that better meets national workforce needs. The education and training of primary care physicians begins with medical student education and continues through and beyond residency training. Such training involves multiple training sites in non-traditional settings (ambulatory sites vs. inpatient hospital wards)and is more expensive than training in traditional sites. The education and training for primary care must be supported at actual cost levels in order to achieve stated objectives.

4. UNIVERSAL ACCESS:

The Community-Based Medical Schools strongly support univeral access to health care by all persons.

5. PUBLIC HEALTH SERVICE INITIATIVES:

A wide range of public health initiatives is essential to provide the infrastructure of health care services to the diverse populations and regions of the country. Funding for these programs under health care reform should be in addition to current base levels and should be financed through a dedicated mechanism that reflects a portion of the total health care premiums and/or other designated public source.

6. CONTINUOUS QUALITY IMPROVEMENT MEASURE:

The MEC must participate in the National Quality Management Council, the National Quality Consortium and regional professional foundations, as specified under the Health Security Act.

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RESPONSES OF DR. JENSEN TO QUESTIONS SUBMITTED BY SENATOR DOLE

Question No. 1. What is your experience in the development of collaborative relationships in which nurse practitioners and others work with primary care physicians in rural settings?

Answer. I have had the opportunity to work with physician assistants and nurse practitioners in a practice setting in a community health center. The Department of Family Medicine is currently responsible for a large segment of the medical students' education. This occurs at the end of the second year (a three week rotation in a rural hospital), during the fourth year (an eight week family practice rotation in rural settings) and at the end of the fourth year (a four week rotation, again in a rural community hospital setting). During these periods, our students have the opportunity to work with all the disciplines—nurses, nurse practitioners, physician assistants, laboratory and x-ray personnel and hospital administrators. It is during these rotations that our students learn to work in a collaborative relationship with primary care physicians, nurse practitioners and the whole spectrum of allied health disciplines.

Question No. 2. Where are the specialists who practice in North Dakota Generally trained?

North Dakota has residency training programs in Family Medicine (four programs), Internal Medicine, Psychiatry and a small Surgical program. Training in the remainder of the subspecialties must be received out of state.

Question No. 3. Obviously your success in meeting the needs of those in North Dakota was largely a result of your ability to design your own program.

In your view, is the answer to the bigger, nationwide problems that face us, a national cap on residencies with a mandatory allocation of slots? Or should we simply remove some of the financial incentives to choosing a specialty and remove the barriers for those who want to set up consortia like your own.

Answer. The answer to question number three would be the second option, "Remove some of the financial incentives to choosing a subspecialty and remove the barriers for those of us who want to set up a consortia such as the North Dakota Center for Graduate Medical Education." There is also a rationale for building in financial incentives for primary care residency programs.

COMMUNICATIONS

STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

On behalf of the over 77,000 members of the American Academy of Family Physicians, please accept this submission for the record of the hearing of the Senate Finance, Committee held on March 8, 1994. We are privileged to have this opportunity to express our views on the physician workforce issues raised in the *Health Security Act*.

Despite a substantial and sustained investment in physician training by the federal and state governments and the private sector, there is a growing disparity between the product of medical education and the health care needs of society. The emergence of the health system reform movement has highlighted the fact that, in addition to having the highest per capita health care costs, the U.S. health care system has the lowest proportion of generalist physicians in the developed world. The evidence linking excess costs to the extreme over-specialization of the U.S. physician workforce has been corroborated in a number of recent studies. Furthermore, the specialty imbalance is steadily worsening. According to projections recently published by the Council on Graduate Medical Education, without changes in the' current physician training pipeline, by the year 2000 there will be a shortage of 35,000 generalist physicians and a surplus of 115,000 specialist physicians. It is eminently clear that if health system reform is to provide universal access to appropriate care within reasonable cost constraints, the proportion of generalist physicians' in practice must be substantially expanded.

Over the past few years there has emerged a growing consensus regarding the need to correct the specialty imbalance (currently 30 percent primary care and 70 percent non-primary care) to one in which there is an even balance between primary care and non-primary care. Organizations supporting a one-to-one ratio between generalists and specialists include the American Medical Association, the American College of Physicians, the Council on Graduate Medical Education, the Association of American Medical Colleges, the Physician Payment Review Commission, and others. The existence of a consensus on the need to correct the specialty imbalance is especially important because the efforts to achieve a balance will require significant changes in current federal policies and aggressive new interventions. These interventions are controversial because they challenge the status quo, but they are essential if we are to achieve affordable and universal access to comprehensive health benefits.

PROVISIONS IN THE HEALTH SECURITY ACT

The mix of physicians currently produced by the U.S. medical education system is a direct reflection of the financial incentives in the federal programs supporting these activities. Specifically, the strong inpatient bias in Medicare's graduate medical education support and Medicare's traditional over-reimbursement of procedural services have powerfully influenced the distribution of the physician workforce toward the procedurally oriented subspecialties. Ironically, while the market for medical care increasingly demands more primary care services, the market facing medical educators continues to provide powerful incentives to produce physicians narrowly trained in subspecialty fields. Changing the specialty mix of the physician workforce will require a reversal in the current incentives and establishing a meaningful connection between the market for medical care and the market for medical education.

The Academy is pleased that provisions of the *Health Security Act* related to the physician workforce constitute a substantial redirection in current federal graduate medical education (GME) policies. Section 3001 of the *Act* establishes a National Council on Graduate Medical Education within the Department of Health and

Human Services. The National Council is required to allocate the designated annual number of specialty positions nationwide among eligible programs on the basis of medical need. At least 55 percent of individuals completing eligible programs must be in primary care (Section 3012). Furthermore, the National Council is required to reduce the total number of residency positions.

Section 3013 of the *Act* requires that the historical distribution of specialty positions among different areas of the country and the quality of each of the programs be included among the factors considered in making allocations among programs. It also provides incentives to increase the number of under-represented minorities in the field of medicine.

With respect to GME funding, approved physician training programs must agree that the number of enrollees in their programs will be in accordance with national goals (Section 3011). The definition of an approved physician training program is expanded to include programs based in ambulatory settings whether or not they also provide inpatient hospital services.

Section 3033 of the *Act* establishes an all-payer health professions workforce account for making payments to eligible programs. Payments are based on the national average of the costs of training residents and will be made directly to the program. In addition, Section 3051 takes into account the short-term strain this shift will place on some subspecialty training centers by authorizing payments to provide transitional support to institutions that lose residency positions.

In addition to the *Act's* provisions related to direct GME support, Medicare's current indirect GME support is replaced by federal formula payments to teaching hospitals and to academic health centers to cover their specialized teaching costs (Sections 3101–3103). These funds would be distributed in proportion to the product of their relative gross receipts for patient care and Medicare's current indirect teaching adjustment. The Secretary is required to report to the Congress by July 1,1996, with any recommendations for allocating funds among centers. Medicare payments for indirect graduate medical education costs are terminated on October 1, 1995. Funds for the annual academic health center account are to come from Medicare, corporate alliances, and regional alliances.

Section 3071 of the *Act* establishes or strengthens existing programs with respect to training primary care physicians. This new focus will include programs (1) to retrain mid-career physicians previously certified in a non-primary care specialty; (2) to expand the supply of physicians with special training to serve in medically underserved areas; (3) to expand the training of under-represented minorities and disadvantaged persons; (4) to expand service-linked educational networks for training in community settings; (5) to provide training in managed care, practice management, continuous quality improvement, and culturally sensitive care; and (6) to enhance information on primary care workforce issues. These programs are to be carried out through existing programs in Titles VII and VIII of the Public Health Service Act.

We believe that the *Act* contains important and essential reforms for achieving an appropriate balance between generalist and specialist physicians. Except for a few small, categorical programs authorized under Title VII of the Public Health Service Act, the current system of funding physician training is characterized by open-ended financing and a complete abdication of accountability for the expenditure of billions of public dollars. Furthermore, no developed nation has been able to achieve an appropriate supply and specialty mix of physicians without taking a much more prescriptive and targeted approach than is currently taken in the U.S. The physician workforce provisions in the *Health Security Act* are an important step toward achieving this end for our nation.

DEFINITION OF PRIMARY CARE

As this committee grapples with strategies for meeting the demand for primary care service, we urge that primary care not be trivialized in the process. The *Act* defines primary care as the specialties of family practice, general internal medicine, general pediatrics, and obstetrics and gynecology. The inclusion of obstetrics and gynecology is contrary to most definitions of primary care and may compromise efforts to address the severe maldistribution of physicians by specialty.

The fact that ob-gyns provide certain services that are within the domain of primary care is well recognized. However, the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in the practice of most ob-gyns or in their training. As defined by the Council on Graduate Medical Education, primary care entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature, and care that includes the coordination of other

health services. In its fullest sense, primary care includes the assessment and evaluation of signs and symptoms initially presented by the patient, the management of acute and chronic medical conditions, the identification and appropriate referral of patients with conditions requiring specialized care, and the provision of health promotion and disease prevention services. While a number of providers receive training in and typically provide some important aspects of primary care, it is only the primary care specialties of family practice, general pediatrics, and general internal medicine that are specifically and fully trained to provide the broad range of primary care competencies. The ob-gyn literature clearly acknowledges the limited role of ob-gyn in the provision of primary care.

As the definition of primary care is used in the *Health Security Act*, it dictates a substantial redistribution of training funds among physician specialties. Because the role of the ob-gyn in primary care is limited, efforts to improve access to primary care will be diluted by including ob-gyn in the definition of primary care. Increasing the training funds for ob-gyn will not substantially improve the number of providers of primary care services. Furthermore, including ob-gyns in the definition of primary care suggests that there are available many more primary care physicians than is, in fact, the case.

It is commonly understood that many women may, by personal preference, choose to obtain the majority of their routine health care from an obstetrician-gynecologist during certain periods of their lives. This is clearly an option that will be preserved under the mandatory fee-for-service plans, and it is expected that many managed care entities will allow women to utilize an ob-gyn routinely. The larger issue is improving access to primary care services. An important part of addressing this issue is training more primary care physicians, which can best accomplished by leaving undiluted the current definition of primary care (family medicine, general internal medicine, and general pediatrics).

We believe it critically important that the traditional definition of primary care (family medicine, general internal medicine, and general pediatrics) be retained.

IDENTIFYING PRIMARY CARE TRAINING PROGRAMS

An issue related to the definition of primary care is the criteria by which primary care residency programs are identified. In order to accurately allocate approved residency positions between primary care and non-primary care specialties, there must be some assurance that graduates of primary care residency programs actually enter primary care practice. A varying proportion of physicians who complete residency training in the primary care specialties elect to subsequently enter subspecialty practice. For family medicine residency graduates this proportion is less than five percent. For internal medicine and pediatrics, the proportion of residency program graduates who elect subspecialty practice ranges from thirty to sixty percent or more.

In order to identify those internal medicine and pediatric residency programs that are dedicated to producing physicians who actually enter primary care practice, the Academy supports a two-pronged approach. The regulatory criteria that are currently employed to identify programs eligible for support under Title VII of the Public Health Service Act are sufficiently stringent that programs identified with these criteria tend to produce a relatively high proportion of primary care physicians. These criteria include faculty experienced in general internal medicine and general pediatrics, selection of trainees who have applied specifically for a generalist program, the use of ambulatory training settings, the provision of continuity of care to a patient population in each year of training, and a planned curriculum emphasizing primary care.

An alternative outcomes criterion would be employed in the case of training programs that do not meet the current Title VII regulatory criteria. Training programs would be eligible for designation as a primary care program if over a three year period an average of 80 percent of its graduates have entered primary care practice three years after completing residency training.

COMPOSITION OF NATIONAL COUNCIL ON GRADUATE MEDICAL EDUCATION

Section 3001 of the *Act* specifies that the membership of the National Council on Graduate Medical Education be representative of consumers, medical school faculty, physicians in private practice, health alliances and health plans. Curiously, in a council that is devoted to overseeing graduate medical education, there is no requirement for representation from physicians who are faculty in residency programs. We strongly recommend that faculty members of generalist residency programs be specified for membership on the National Council in lieu of faculty members of medical schools.

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CAP ON AGGREGATE NUMBER OF TRAINING SLOTS

Section 3012 of the Act requires the National Council to ensure that the total number of residency positions be reduced to a number that bears a relationship to the number of graduates of U.S. medical schools and takes into consideration the need for additional physicians. Implicit in this provision is a broad consensus on an aggregate surplus of physicians in the U.S. The U.S. Bureau of Health Professions projects an overall surplus of 80,000 physicians by the year 2000, rising to a surplus of 200,000 by the year 2020.

Due to the long length of the physician training pipeline, any limit on the number of residency positions will not have a perceptible impact on the physician supply for well over a decade. Because of the size of the physician surplus, the Academy believes that the *Health Security Act* should specify a tighter limit on the number of first year residency slots than is currently provided. Specifically, there should be established an initial limit on the number of first-year allopathic and osteopathic residency positions of no more than 110 percent of the number of 1993 U.S. allopathic and osteopathic medical school graduates. As part of its on-going duties the National Council on Graduate Medical Education should develop and propose recommendations to revise the limit on residency slots by the year 2000. This recommendation is consistent with one recently proposed by COGME. The change lies in fixing the aggregate number rather than letting it float based on the number of graduates produced by the medical schools. According to COGME, it would reduce the number of approved positions from 24,000 to 19,000, and would result in a leveling of the growth of the physician supply relative to population by 2010.

SUPPORT FOR AMBULATORY AND PRIMARY CARE TRAINING

The Academy believes that graduate medical education funding must be revised in a manner that recognizes the changing realities of medical practice. An increasing proportion of medical care is now delivered in the ambulatory setting. As a result, inpatient hospital utilization has steadily declined. In contrast, current GME funding is, for all practical purposes, only available to inpatient institutions and provides powerful incentives to focus on training in inpatient care. If the U.S. physician workforce is to be responsive to actual health care needs, the health system must provide substantially greater support to ambulatory training. In this regard, the workforce provisions of the *Health Security Act* are a good start, but they could be substantially improved.

As noted above, the *Health Security Act* proposes to establish an all-payer GME fund based on a national average per-resident training cost. Currently, Medicare direct GME payments are based on cost reports submitted by each sponsoring institution, and per residents amounts range widely from approximately $10,000 per year to well over $100,000 per year. Establishing a national average per resident cost helps address this unjustifiably wide variation in direct GME payments. However, training in the ambulatory setting is substantially more expensive than training in the inpatient setting. We are concerned that payments based on average per-resident training costs will be inadequate to support residency programs that contain a large ambulatory component. Typically, it is the primary care specialties that emphasize ambulatory training.

Our concern regarding inadequate direct GME payments based on a national average per-resident amount is heightened by the Act's provision related to indirect payments. As noted above, support for indirect teaching costs will continue to be funneled exclusively through inpatient facilities and will do little to support the ambulatory training of primary care physicians.

In order to adequately fund ambulatory and primary care training, it will be necessary to direct a larger proportion of the GME funding in the *Health Security Act* to programs in the primary care specialties. The Academy recommends that Section 3033 be amended so as to up-weight direct payments to primary care residency programs by a factor of two. Payments to programs in the non-primary care specialties would be adjusted to achieve budget neutrality.

CONSORTIA

Section 3013 of the *Health Security Act* requires the National Council on Graduate Medical Education to allocate the designated annual number of specialty positions nationwide among eligible training programs. We believe that after setting national goals related to the aggregate number of training positions and the primary care—non-primary care mix of specialties, the actual allocation of approved positions to training programs should be accomplished through a more decentralized process. Specifically, the Academy supports the allocation of residency positions to

be funded and the distribution of GME training funds through regional or state training consortia operating within broad national goals related to the aggregate number and specialty mix of training positions. GME training funds should be distributed to the legal entity sponsoring the residency program. This approach would provide for more private sector involvement and would be more sensitive to local needs.

Each consortium should be a non-profit entity broadly composed of all institutions in the region or state that legally sponsor residency training programs. Other institutions with an interest in graduate medical education, such as medical schools, may serve the consortia in an advisory capacity. Each consortium should be governed by a board of directors elected by the members of the consortium.

In regard to the specific role of medical schools in consortia, we note that only one-third of family practice residency programs are administered by medical schools. Many medical school environments socialize medical students away from career interests in family practice. However, since medical schools will need to prepare students for career choices in available residency positions, it is important that medical schools be involved in consortia activities.

Two or more consortia should be allowed to enter into negotiations regarding the distribution of residency positions such that the aggregate number and specialty mix conform with national goals specified by National Council on Graduate Medical Education. However, no consortium should have less than 40 percent of its approved residency positions in the primary care specialties of family medicine, general internal medicine, and general pediatrics. This recommendation provides some limited flexibility in meeting the national goal of 50 percent primary care. However, it establishes a floor of 40 percent, below which no consortium can fall. This floor is established to emphasize the shift to a primary care-based model of health care delivery in all areas of the country, and the necessity for all medical education and training institutions to be directly involved in meeting the public's need for primary care physicians.

Within the limitations set by the Act, the National Council on Graduate Medical Education sets national goals related to the aggregate number of residency positions and the minimum percentage of positions in the primary care specialties. Except as noted below, consortia would approve residency positions in a manner that is consistent with national goals and responsive to the need for medical care within the state or region. NCOGME should review consortia decisions related to the specific number and specialty mix of approved residency positions for conformance to national goals. In addition, NCOGME may modify national goals related to specific specialties that remain in under- or over-supply. This provision recognizes that in certain very narrow specialties, training programs prepare graduates for a national rather than regional market. It establishes a mechanism to address a situation wherein the aggregate decisions of all consortia fail to address current or projected shortages of physicians in specific specialties. For example, it may be that in the aggregate consortia fail to provide for a sufficient number of training positions in preventive medicine or child psychiatry. NCOGME should be able to make specific modifications in national goals and negotiate with specific consortia to ensure that such shortages are addressed.

SUPPORT FOR FACULTY DEVELOPMENT

The vast majority of family practice residency program graduates enter clinical practice. Consequently, a major impediment to the expansion of family practice residency programs is a shortage of trained and experienced faculty. The Academy believes that among the related programs established in Section 3071 should be a substantial expansion in the funds available for primary care faculty development. This is a critical variable in successfully accomplishing the goal of increasing the production of family physicians.

PRIMARY CARE RESEARCH

In Sections 3201 and 3202, the *Health Security Act* establishes new health research initiatives in health promotion and disease prevention and health services research. While these are important, the Act omits a highly relevant and to date largely ignored area of primary care research.

For the past 30 years, over 95 percent of all medical conditions have been evaluated and treated outside of hospitals. However, the traditional focus of medical education and research has been on medical problems in referred and hospitalized patients. Thus, the training of physicians and the research agenda have focused almost exclusively on inpatient rather than outpatient evaluation and treatment.

The National Institutes of Health and the Agency for Health Care Policy and Research have given only the most limited attention to primary care research. A Section 3203 should be added to specify a third focus for new funding for research in primary care, which is defined as research related to better assisting the generalist physician in diagnosis and treatment of the undifferentiated patient population treated in the ambulatory care setting.

Priority areas for primary care research should include:

- Research to better understand the role of diagnosis in family practice and primary care so as to assist the generalist physician with evaluating the myriad symptoms of the patient, differentiating self-limited diseases from those requiring ongoing or intensive treatment and initiating effective treatment. The tangible benefits of such research could streamline the diagnostic process, increase accuracy, and reduce the use of expensive and potentially dangerous medical tests.
- Research to improve the effectiveness of medical care as the physician, in collaboration with the patient, designs and implements an effective treatment that reconciles the idiosyncrasies, preferences and the needs of the patient with the realities of the illness.
- Research to improve access to health care and the cost-effectiveness of care focusing on the role of frontline, generalist physicians.

PHYSICIAN RETRAINING

There is a clear consensus on the need to train more generalist physicians as well as to provide incentives for more medical students to choose generalist careers. We believe that priority must be given to the support of generalist graduate medical education programs and those elements of the undergraduate medical school environment that influence student career choices. However, the large pool of excess subspecialty physicians, if provided with appropriate training in the primary care competencies, constitutes another potential short-term solution to the shortage of generalist physicians.

Few models for physician "retraining" currently exist. Short, continuing medical education programs provide little quality assurance and no generally accepted measures of competence. Longer, GME programs, at the other extreme, lead to board certification, but take a minimum of two to three years and are oriented toward recent medical school graduates rather than to limited specialists who seek retraining.

A host of retraining issues remain unresolved. Are there alternative retraining models shorter than full board certification, but with more assurance of competence than continuing medical education courses? Can limited specialists be retrained into generalists on a part-time basis in less than two years while maintaining an income sufficient to meet personal financial obligations? What are the primary care competencies that should be taught to such a group? How can appropriate candidates for retraining be identified and how can their individual educational needs be addressed? How much demand will there be from limited subspecialists to undertake retraining? Given the chronic shortage of family practice residency program faculty, who will be available to teach retrainees? By what processes will the competency of retrainees be evaluated? Will retrainees be eligible for board certification?

Based on the relatively limited data that exist on physician retraining, the Academy recently developed the following recommendations.

First, family practice residency training leading to board certification should be promoted as the prototype model for training physicians seeking skills in primary care. Second, flexible part-time models of residency training should be developed and promoted. Third, new curricular models geared to meeting the individual training needs of physicians entering family practice residency education should be developed and encouraged. Fourth, managed care delivery systems should be encouraged to develop flexible and part-time retraining models within family practice residency programs.

Fifth, the capacities of family practice residencies should be expanded with added resources to provide focused primary care educational opportunities for physicians that do not lead to board certification. This model of "on-the-job" continuing medical education may be through short courses (mini-residencies) or longer part-time programs.

Sixth, federal GME support should be available for all residents enrolled in family practice residency programs, regardless of previous training. Seventh, the Public Health Service should support demonstration projects in physician retraining with funds in addition to those already committed to the training of physicians through Title VII.

Finally, HMOs and other managed care organizations should be encouraged to develop family practice residency programs.

CONCLUSION

We appreciate the opportunity afforded us by the committee to comment on the physician workforce issues in the *Health Security Act.* It is not possible for us to emphasize strongly enough that workforce reforms are essential to the success of health system reform, no matter what your vision of health reform might be. We look forward to working with the Congress in addressing these and many other important health care issues.

ISBN 0-16-046649-0